

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

10877

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10861
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 1 Hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Richard Last Adams		4. DATE OF DEATH Month Oct. Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1959
9. AGE (In years last birthday) 1 yrs. 8 mos. 20 days		IF UNDER 1 YEAR Months 8 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Jr. Adams		14. MOTHER'S MAIDEN NAME Anna Mae Zies	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John Adams		Address Ridgeley, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434-4 IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE (HEMOTHORAX) 3-4 Days DUE TO Conditions, if any, which gave rise to immediate cause (b) CARDIAC HYPERTROPHY; CONGENITAL PUL- (c) MONARY STENOSIS; ADRENAL ATROPHY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3-4 Days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarellic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED OCTOBER 21, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/1960	
22c. NAME OF CEMETERY OR CREMATORY Forrest Glenn Cem.		22d. LOCATION (City, town, or county) (State) Green Spring, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR OCT 25 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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10878

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10862

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLYDE Middle Alphonso Last APPOLD				4. DATE OF DEATH Month 10 Day 30 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1901	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 30 Hours 10 Min.		IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Queen City Brewery		11. BIRTHPLACE (State or foreign country) Magnolia, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM Z. APPOLD (D)				14. MOTHER'S MAIDEN NAME MARY E. STOTT (D)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-4986		17. INFORMANT Mr. Donald C. Appold Address 937 Md. Ave., Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO hepatic coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) crisis of the liver DUE TO (c) 6 months						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-15-1960 to 10-30-1960 , that (I) (we) last saw the deceased alive on 10-30-1960 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
22a. SIGNATURE L. Brings				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) LOUIS BRINGS, M.D.				22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10863**

10879

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 10 Min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ross Middle BAGLEY Last BAGLEY				4. DATE OF DEATH Month OCTOBER Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1887	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73		IF UNDER 24 HRS. Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY PRR Railroad		11. BIRTHPLACE (State or foreign country) Bedford, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Bagley				14. MOTHER'S MAIDEN NAME Minnie Spiece			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 716-10-6687			
17. INFORMANT Ross Bagley, Jr., Severna Park, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (c) CORONARY SCLEROSIS DUE TO (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 1 Hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitabelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITABELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler				ADDRESS Hyndman, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24a. REC'D BY REGISTRAR DATE OCT 19 '60							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

10803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATEMENT OF DEATH - EXHIBIT 10

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is mostly blank with some faint text visible.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10880

10880

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 19 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL AVE.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle Last BARBER				4. DATE OF DEATH Month OCTOBER Day 28 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 23, 1914	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Operated	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GILMORE, MD.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME RALPH BARBER				14. MOTHER'S MAIDEN NAME JENNIE MUIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY SCLEROSIS WITH OCCLUSION, LEFT DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC VASCULAR DISEASE (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 Hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF THE LIVER							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> OCT. 28, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/60		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE NOV 1 '60	
24b. REGISTRAR'S SIGNATURE <i>Christina S. Hous</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Medical Examiner's Certificate of Death

11. 2020-01-01-2020-01-01-2020-01-01

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10881

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10865

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 6 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY ALLEGANY <i>Garrett</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE <i>11X-2</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHRISTINE Middle M Last BENDER		4. DATE OF DEATH Month OCTOBER Day 7 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 2, 1906 9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) CELLIN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHRISTIAN BEACHY		14. MOTHER'S MAIDEN NAME ALENA J. BITTINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-42-4222	
17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 hrs 3 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Cumbersville Allegany MD	
21. I certify that (I) (this hospital) attended the deceased from 10/3/60 19 to 10/7/60 19, that (I) (we) lost saw the deceased alive on 10/7/60 19, and that death occurred on 10/7/60 19 at 3:15 PM from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS Cumbersville MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/10/60	
23c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		23d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT CO MD	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 13 '60	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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ALBANY
CHARTERED
GENERAL HOSPITAL, INCORPORATED
GRANTON, N.Y.
CHRISTINE
WHITE
MAY 2, 1902
DEPT. OF LAND
ALBANY, N.Y.
GENERAL HOSPITAL, INCORPORATED, N.Y.

[Faint, illegible text and signatures follow]

may be reviewed by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10882

CERTIFICATE OF DEATH

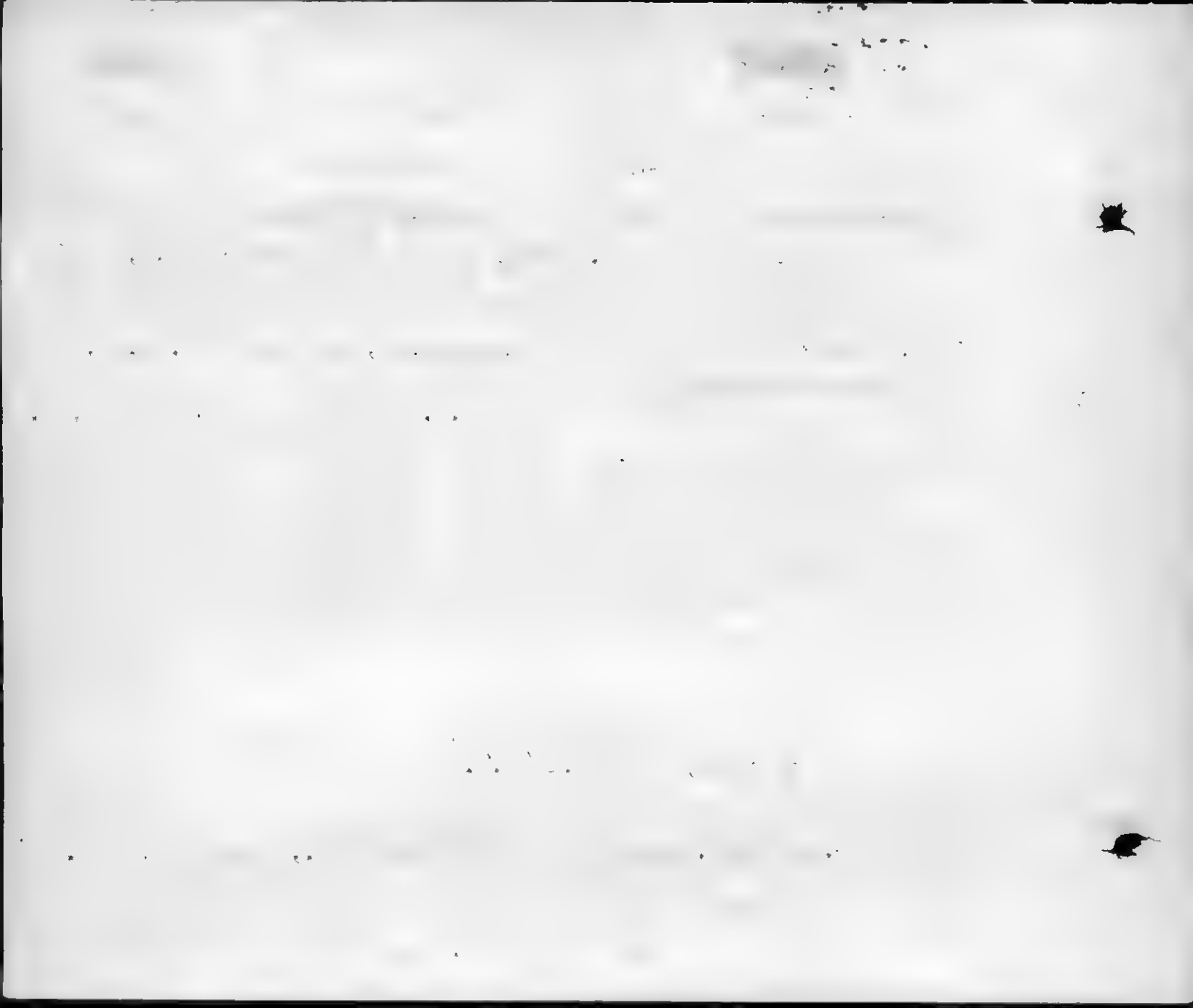
10866

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9/17/60		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 12 Island Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nell Middle P. Last Berkenbaugh				4. DATE OF DEATH Month October Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/1875	
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 17 Min.		11. IF UNDER 24 HRS Months 8 Days 17 Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Clerk				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leopold Berkenbaugh				14. MOTHER'S MAIDEN NAME Sarah Rowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT P.O.Box 599, Allegany County Infirmary Records Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocardial Degeneration DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary anemia DUE TO (c) Senile psychosis							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/17/60 , 19 60 , to 10/17/60 19 60 , that (I) (we) last saw the deceased alive on 10/17/60 19 60 , and that death occurred at 5:15 P.M. M, from the causes and on the date stated above							
22a. SIGNATURE James E. McLean M D				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/18/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/1960		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.		25a. REC'D BY REGISTRAR DATE OCT 21 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

M

071

1



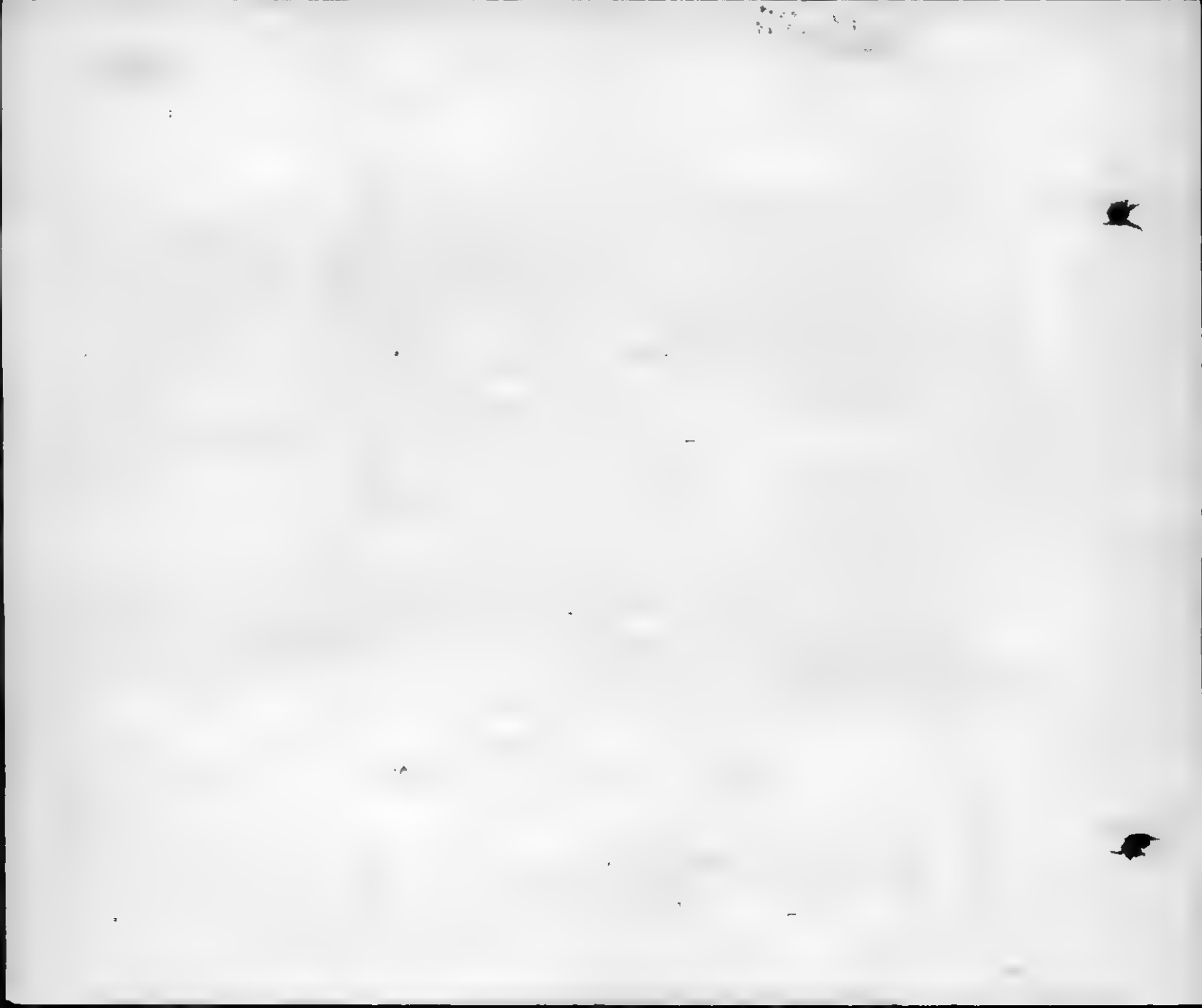
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10927

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10867

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 18 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle S. Last BLAKE		4. DATE OF DEATH Month OCTOBER Day 1 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PIPE FITTER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILLIP BLAKE		14. MOTHER'S MAIDEN NAME MARGARET BEAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-6145	
17. INFORMANT Address MRS. CLARA BLAKE, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 DUE TO Myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 644 DUE TO 644 (c)		INTERVAL BETWEEN ONSET AND DEATH 644	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 6 1960 to Oct 1 1960 , that (I) (we) last saw the deceased alive on Oct 1 1960 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE W. O. McLane M.D.		22b. DATE SIGNED Oct 3/60	
22c. PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-3-60	23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR'S SIGNATURE J. H. Burst ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR OCT 4 '60	25b. REGISTRAR'S SIGNATURE William J. Hume



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay. This certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10868

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital (DOA)				d. STREET ADDRESS 147 Hanover St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian M. Boston				4. DATE OF DEATH Month Day Year October 25, 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Douglas Fisher				14. MOTHER'S MAIDEN NAME Minnie Yonker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. William Walker Pittsburg, Pennsylvania			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN **---	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct., 28, 1960		22c. NAME OF CEMETERY OR CREMATORY Summer Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Forrest Sklarevic				ADDRESS 117 Frederick St. Cumb. Md.		24a. REC'D BY REGISTRAR OCT 27 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

VS. A1 (5)
SM 9/55

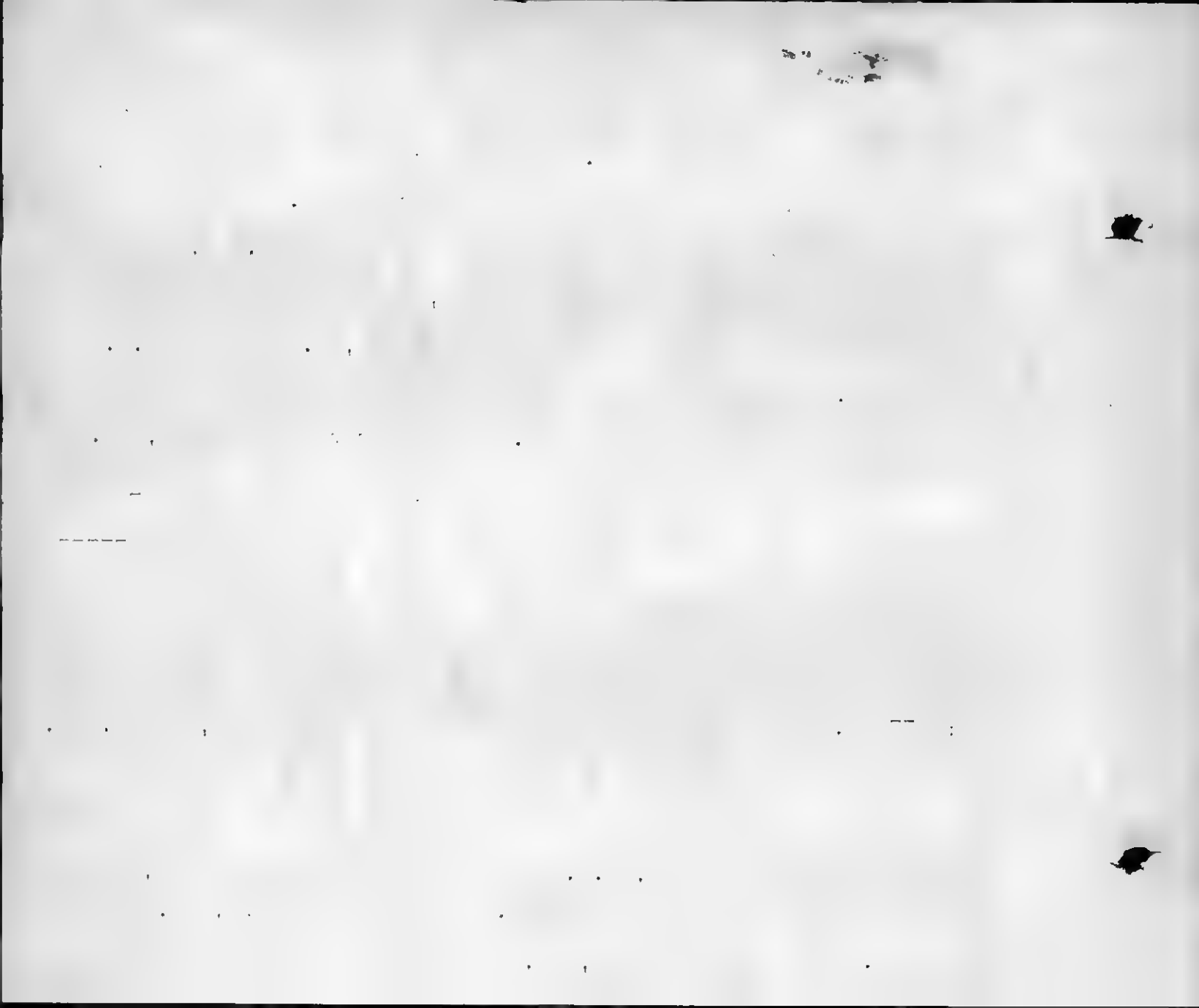
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10884 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10869

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 Da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 21 Harrison St.			
3. NAME OF DECEASED (Type or print) First Margaret Middle Ethel Last Boward				4. DATE OF DEATH Month Oct. Day 21 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1879		9. AGE (in years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Leonard R. Boward				14. MOTHER'S MAIDEN NAME Matilda Mock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Aletha Kerns Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) due to the underlying cause lost. DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2-3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF LEFT HIP							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) FELL OF CHAIR AT HOME					
20c. TIME OF INJURY Month, Day, Year 10:30 a.m. Oct. 11 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 21, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 25 '60	
						24b. REGISTRAR'S SIGNATURE Charles L. George	

DATE SIGNED



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

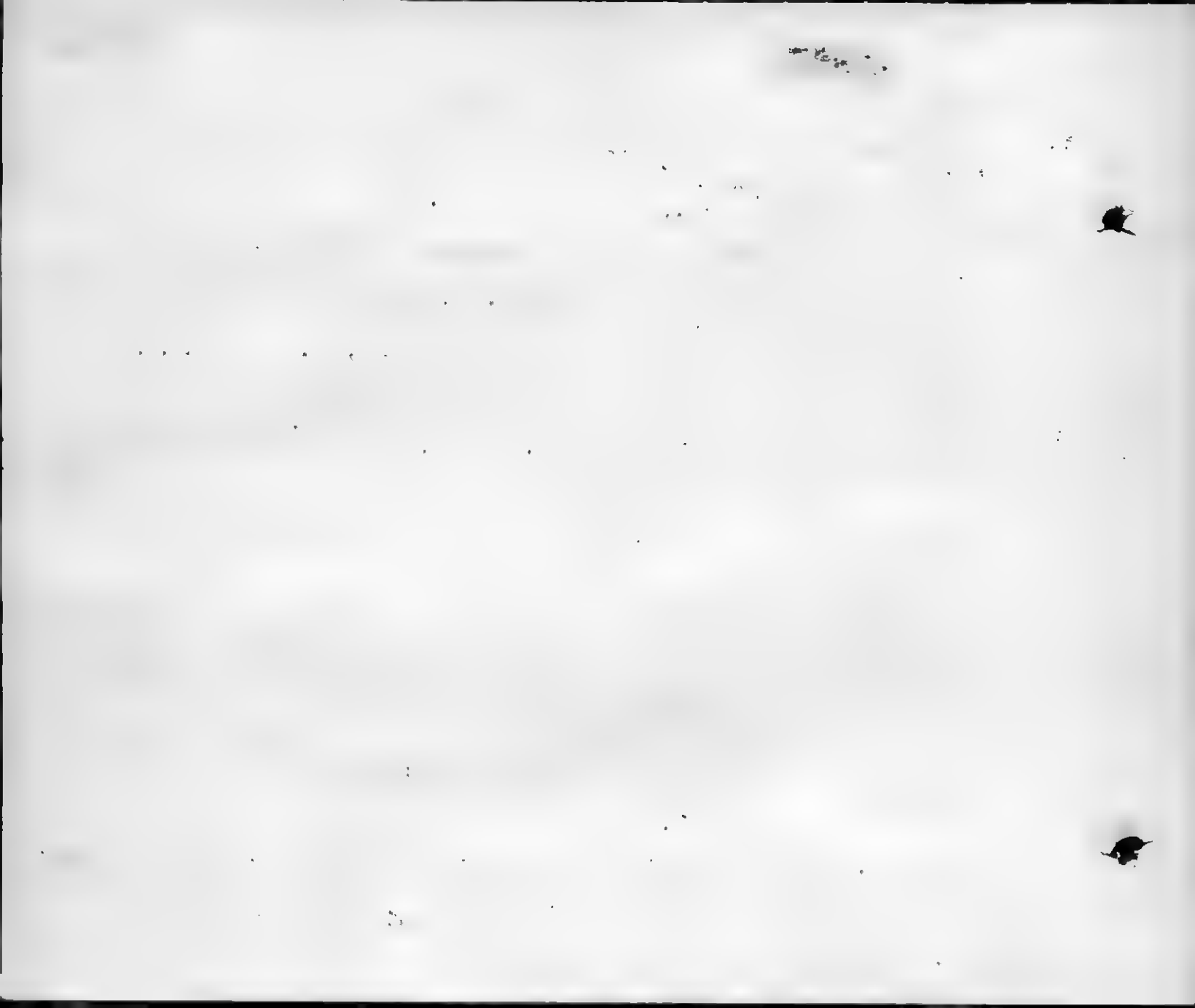
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10885

10870

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 57 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle HERMAN Last BROWNING				4. DATE OF DEATH Month OCTOBER Day 9 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 22, 1897	
9. AGE (In years last birthday) 63 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) FLINTSTONE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EPHRAIM BROWNING				14. MOTHER'S MAIDEN NAME CLARA HAMILTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-36-9864		17. INFORMANT Mrs. Willa H. Browning Rt. 2 Address Flintstone, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) Arteriosclerotic Hypertension Contributing to Myocardial Infarction (c) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH Minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Oct 1960 , that (I) met last saw the deceased alive on Oct 4, 1960 , and that death occurred at 12:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. Overton Himmelwright M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 10/10/60			
22c. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT				22d. ADDRESS 1331 11th Ave, Cumberland, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland ADDRESS				25a. REC'D BY REGISTRAR OCT 17 '60 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Haas	

MEDICAL CERTIFICATION



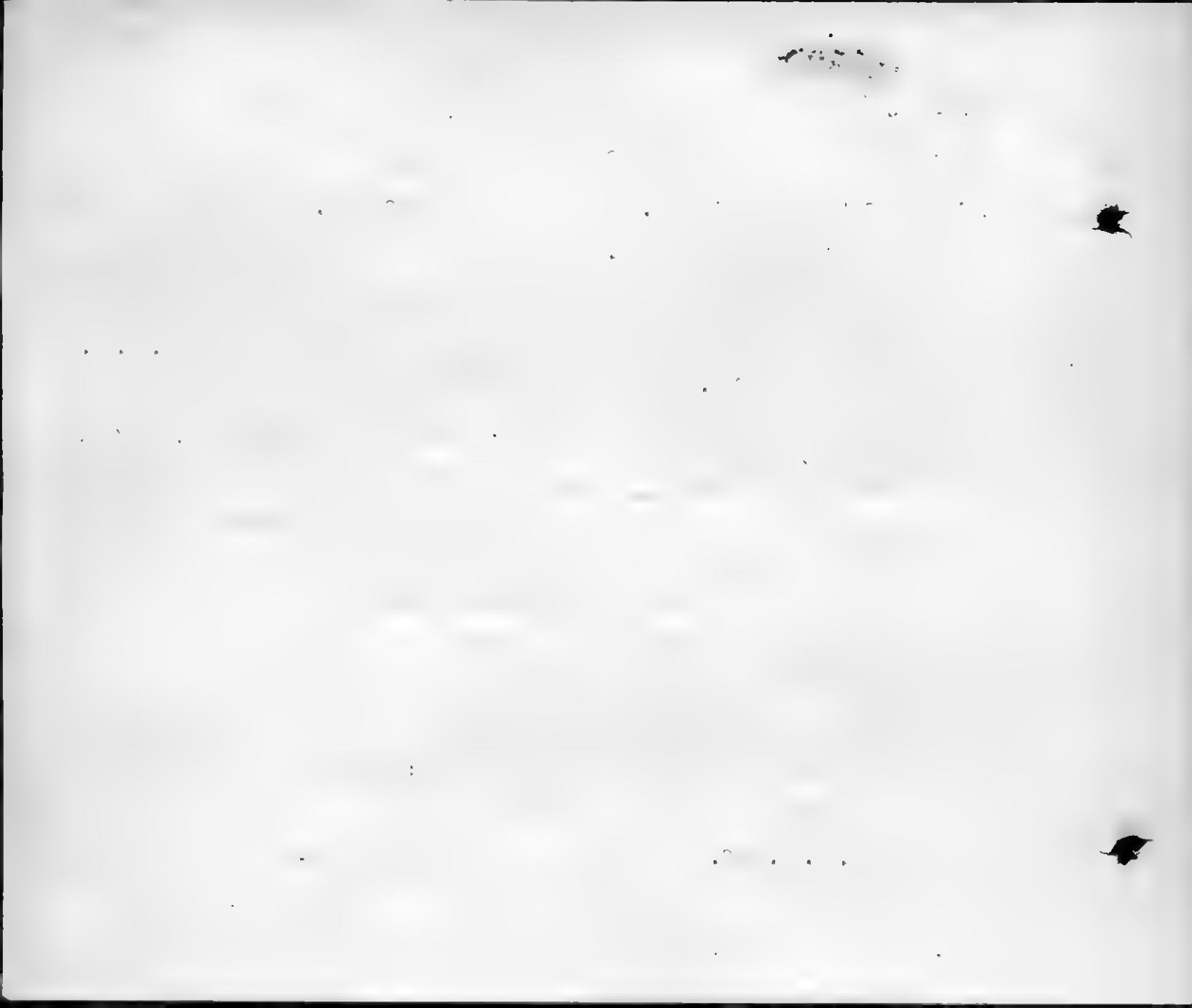
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
10886
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10871

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.		d. STREET ADDRESS 406 PULASKI ST.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM H. BULEY		4. DATE OF DEATH Month Day Year OCTOBER 14 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27, 1883
9. AGE (In years last birthday) yrs 77		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY City Employee	
11. BIRTHPLACE (State or foreign country) MARYLAND, Flintstone		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES M. BULEY		14. MOTHER'S MAIDEN NAME JULIA DIEHL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerotic Cardiovascular Disease 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH Since July 14	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o m p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7.16.1944 to 10.14.60 that (I) (we) lost saw the deceased alive on 10.14.60 and that death occurred on 10.14.60 from the causes and on the date stated above.			
22a. SIGNATURE W. F. Wms.		22b. DATE SIGNED 10/15/60	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WMS.		22d. ADDRESS Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10887

10872

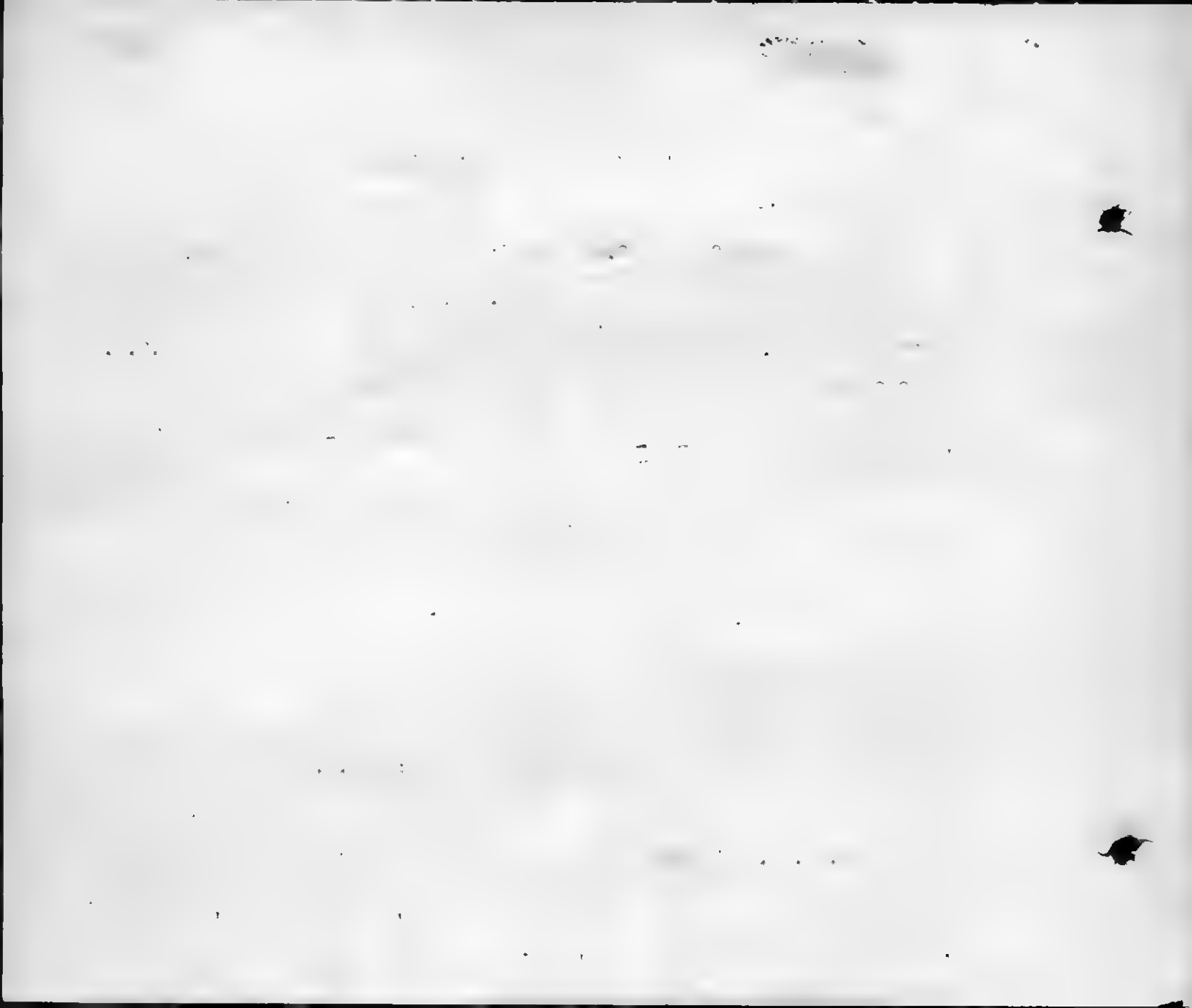
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GLADYS Middle BURKETT Last				4. DATE OF DEATH Month OCTOBER Day 6 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 13, 1910		9. AGE (In years last birthday) 50 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWIFE & Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Ladies Hosiery Shop		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES STAUP				14. MOTHER'S MAIDEN NAME GRACE WADDELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-16-2053		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart cell lymphoblastoma with 302.1 DUE TO extensive generalized recurrences Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and arteriosclerotic vascular disease							INTERVAL BETWEEN ONSET AND DEATH 6 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18th to 6 Oct , 19 60 , that (I) (we) last saw the deceased alive on 5 Oct 19 60 and that death occurred at 6:25 A.M. from the causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer M.D.				22b. DATE SIGNED 6 Oct. 60		22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER	
22d. ADDRESS 172 S. Centre St. Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				25a. REC'D BY REGISTRAR DATE OCT 10 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1

(M)

060

(1)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10939
CERTIFICATE OF DEATH

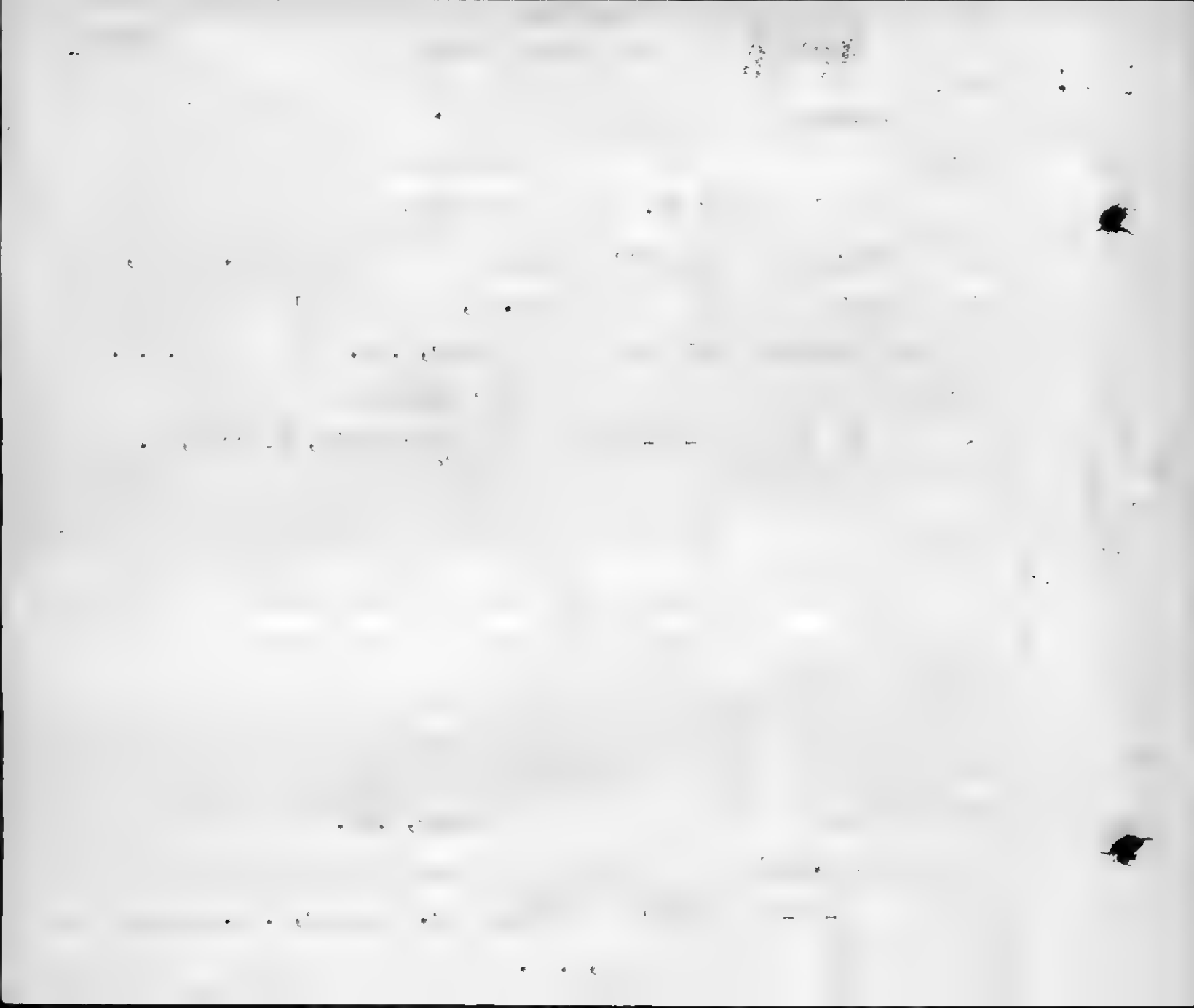
10873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home 160 Queen St.				e. STREET ADDRESS 160 Queen			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry Middle Clifford Last Cain				4. DATE OF DEATH Month Oct. Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Road Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Rail Road		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Goff Cain				14. MOTHER'S MAIDEN NAME Mary Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-07-9703		17. INFORMANT Address Lillian Tharp Cain, McCoole, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (Wife) DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Rheumatoid Arthritis</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Unknown</p> </div> </div>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from past 19 months , 19 that I last saw the deceased alive on 10/10 , 19 60 , and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Keyser, W. Va. DATE SIGNED ACTUAL SIGNATURE Paul Healy M.D. Keyser, W. Va. PHYSICIAN'S NAME (Type) Paul T. Healy							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-60		22c. NAME OF CEMETERY OR CREMATORY Potomac Valley Memorial Gardens Inc.		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas Smith Jr. ADDRESS Keyser, W. Va.				24a. REC'D BY REGISTRAR OCT 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

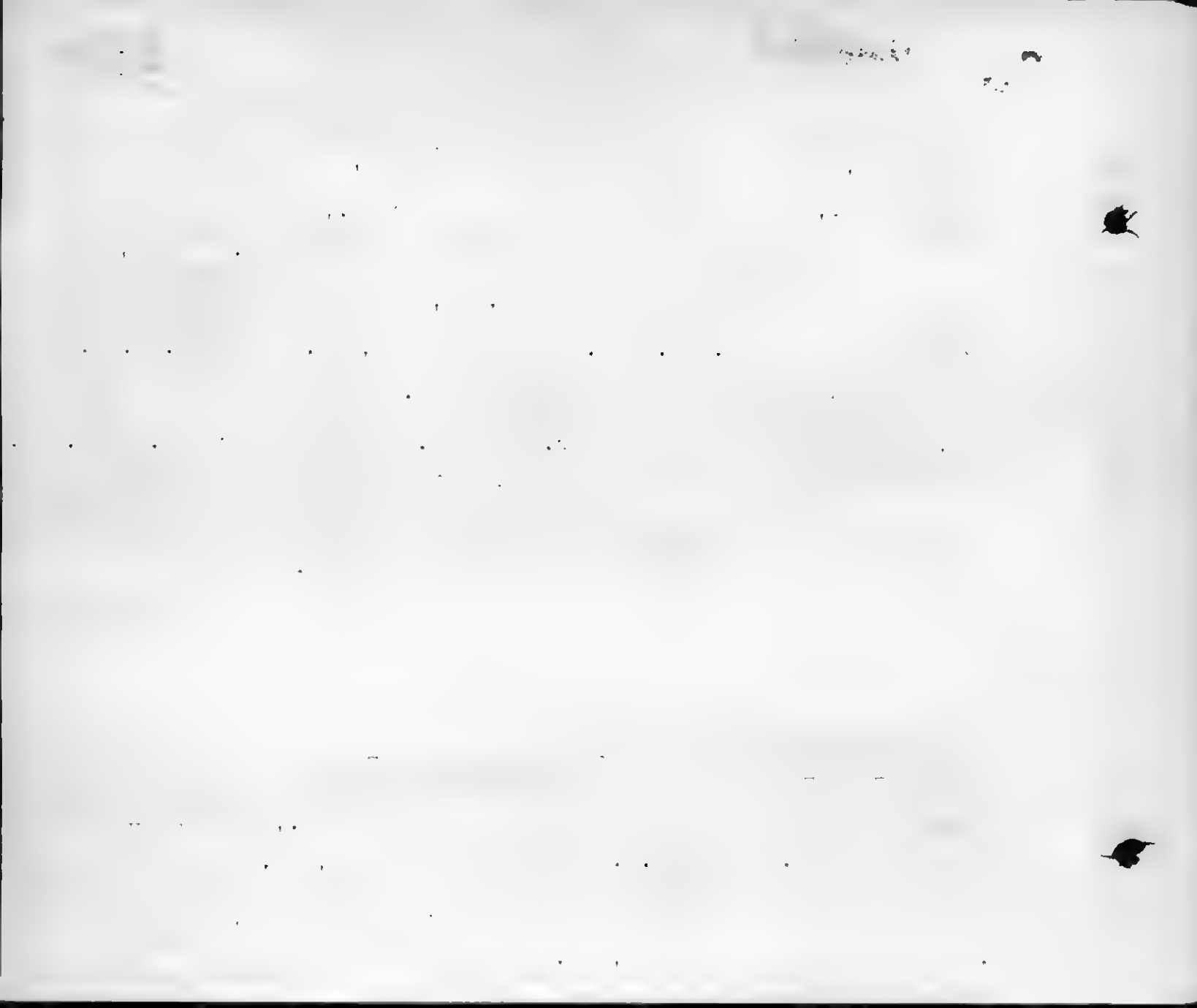


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10888
CERTIFICATE OF DEATH

Reg. Dist. No. 10874

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Water St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle BENEDICT Last CESSNA		4. DATE OF DEATH Month Oct. Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1896
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months 6 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caller		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.	
11. BIRTHPLACE (State or foreign country) Cresaptown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Cessna		14. MOTHER'S MAIDEN NAME Sara A. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Mr. Elmer E. Cessna Bedford Rd. Cumb. Md.	
17. INFORMANT Mr. Elmer E. Cessna Bedford Rd. Cumb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 - 28 , 1949 , to 10 - 27 , 1960 , that I last saw the deceased alive on 10 - 27 - 1960 , and that death occurred at 11:30 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St., DATE SIGNED 10-28-60			
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St., 10-28-60	
PHYSICIAN'S NAME (Type) Ralph W. Ballin M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/60	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 1 '60		24b. REGISTRAR'S SIGNATURE William S. Thomas	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

10940

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10875

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		c. LENGTH OF STAY IN lb <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 4.</u>				d. STREET ADDRESS <u>Route 4.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARETHA</u> Middle <u>W.</u> Last <u>CHANEY</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>11</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Luhnow</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Kuchenbecker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Harold B. Chaney, Route 4, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>OCTOBER 11, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION



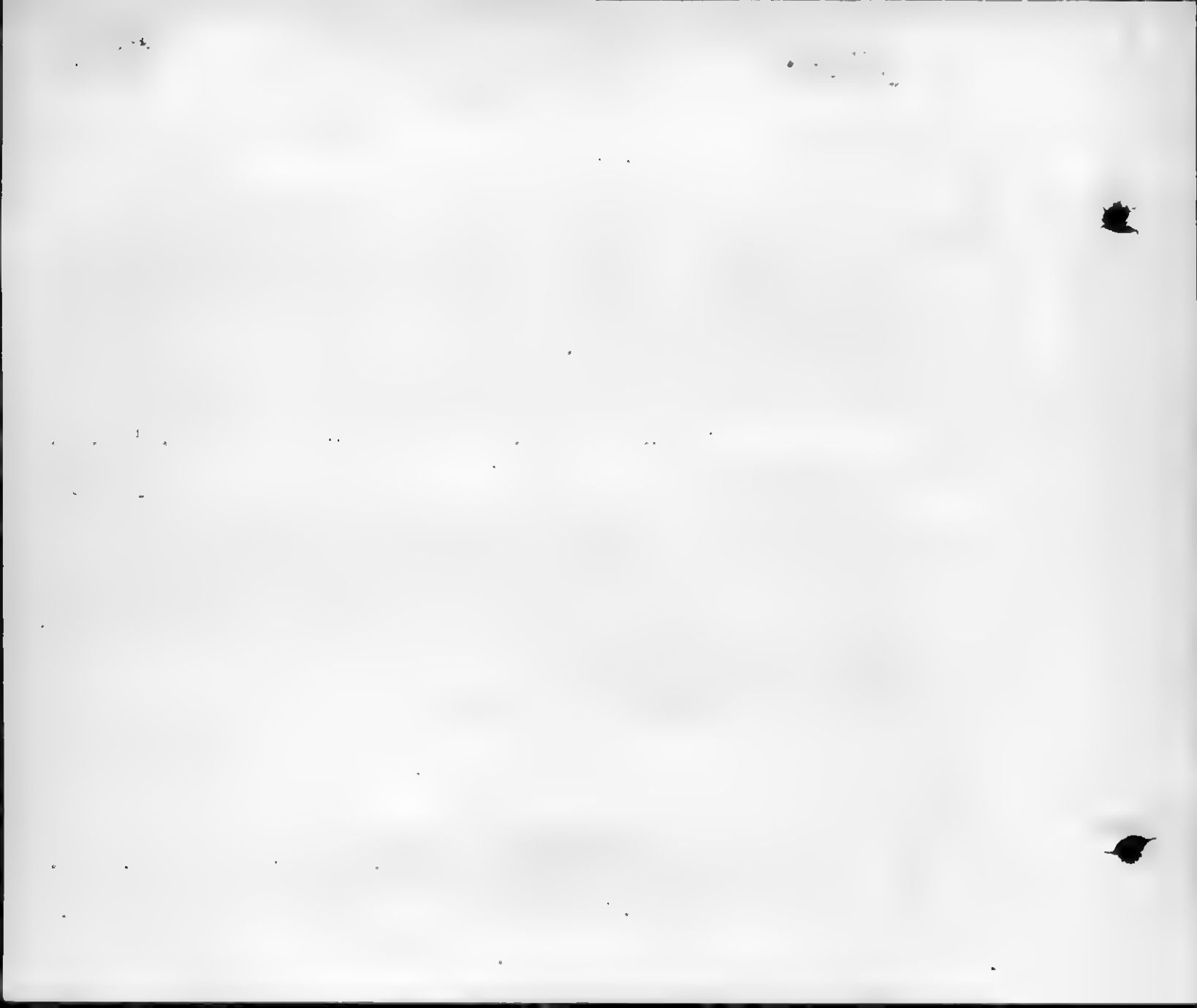
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10928

10876

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 High Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Ronald Cosgrove				4. DATE OF DEATH Month Day Year October 31st, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9th, 1896	9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-City Clerk		10b. KIND OF BUSINESS OR INDUSTRY Police Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Cosgrove				14. MOTHER'S MAIDEN NAME Mary Ellen Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 217-10-5159		17. INFORMANT Address Mrs. Zura Cosgrove, 13 High St. F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia, DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary anemia.							INTERVAL BETWEEN ONSET AND DEATH 6 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-1 1960 to 10-31 1960 ; that (I) (we) last saw the deceased alive on 10-31 1960 and that death occurred at 9 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE H. C. Diehl				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/1/60	
22c. PHYSICIAN'S NAME (Type) H. C. Diehl,				22d. ADDRESS 39 W. Main St., Frostburg, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-2-60		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE NOV 3 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(J)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

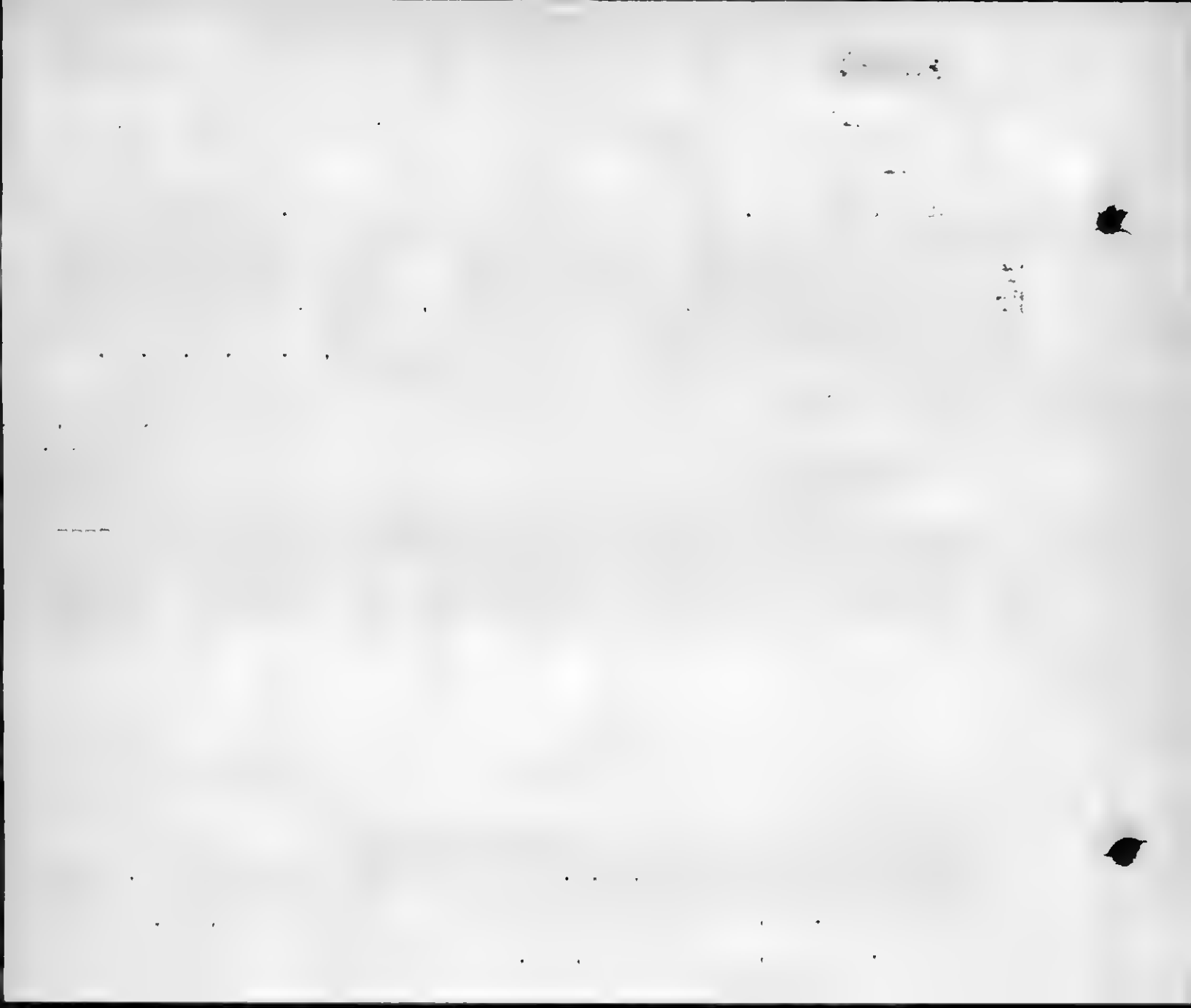
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10889

10877

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 Eastern Ave.		d. STREET ADDRESS 525 Eastern Ave.	
3. NAME OF DECEASED (Type or print) First ANNIE Middle MARY Last CROSS		4. DATE OF DEATH Month October Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1879
9. AGE (in years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Morgan County, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Sheppard		14. MOTHER'S MAIDEN NAME Matilda Lowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Francis Atkinson		Address Cumberland, Md. 525 Eastern Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> OCTOBER 21, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 24 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



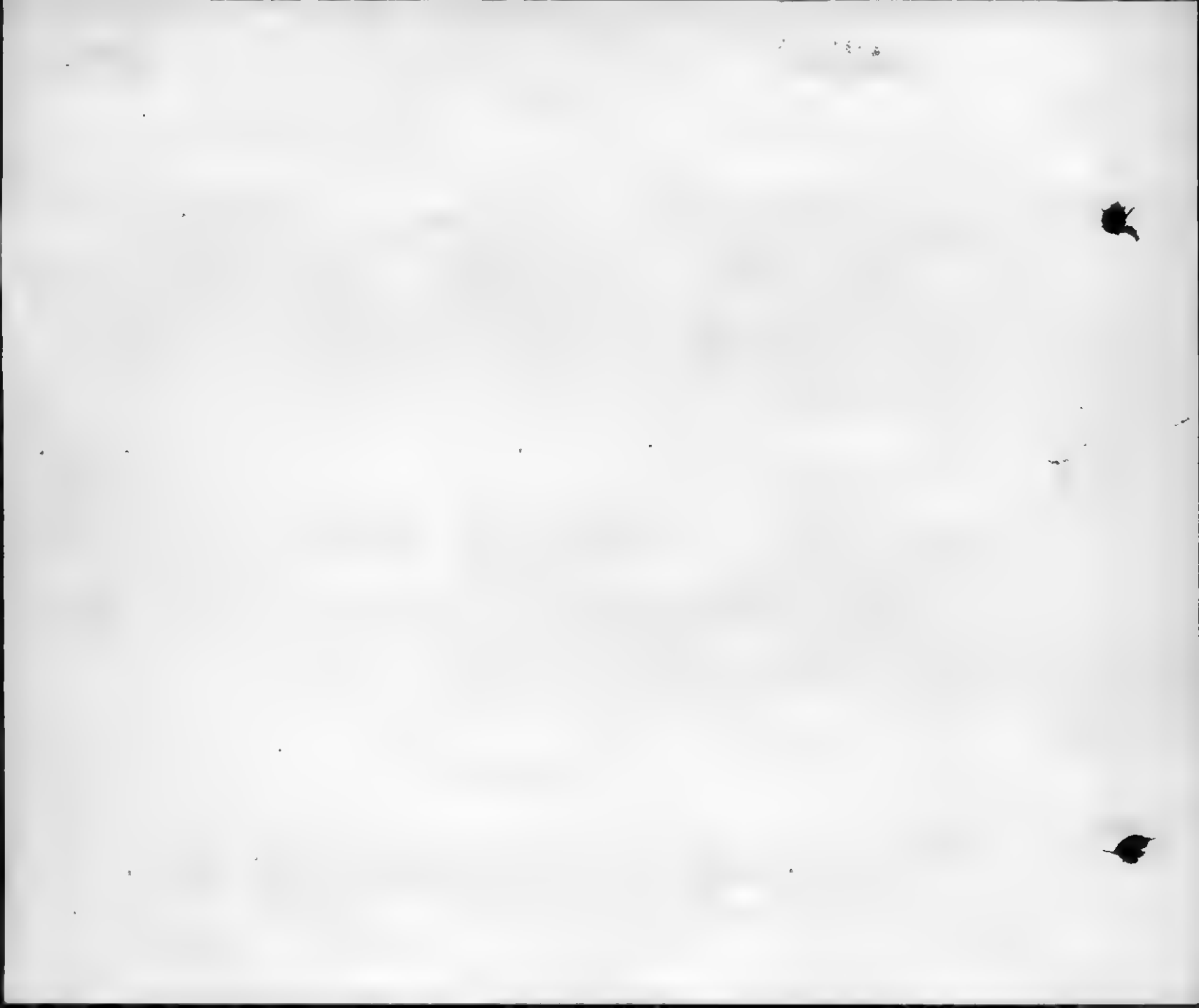
may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10929

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10878

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Willard Last Davis				4. DATE OF DEATH Month October Day 14th Year 19 60			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH July 31st, 1899	9. AGE (In years lost birthday) 61 yrs	IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Band Builder		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Sprf. Tire Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Davis				14. MOTHER'S MAIDEN NAME Mary A. House			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO 712-14-1665		17. INFORMANT Mrs. Cleo D. Henry, 168 Spring St., F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO (b) Hypertensive Cardiovascular dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) years				INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 1949 to Oct 14, 1960 that (I) (we) last saw the deceased alive on Oct 14, 1960 and that death occurred at 6 PM , from the causes and on the date stated above							
22a. SIGNATURE John B. Davis, M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/15/60	
22c. PHYSICIAN'S NAME (Type) John B. Davis,				22d. ADDRESS 2 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-60		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Christ				25a. REC'D BY REGISTRAR OCT 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

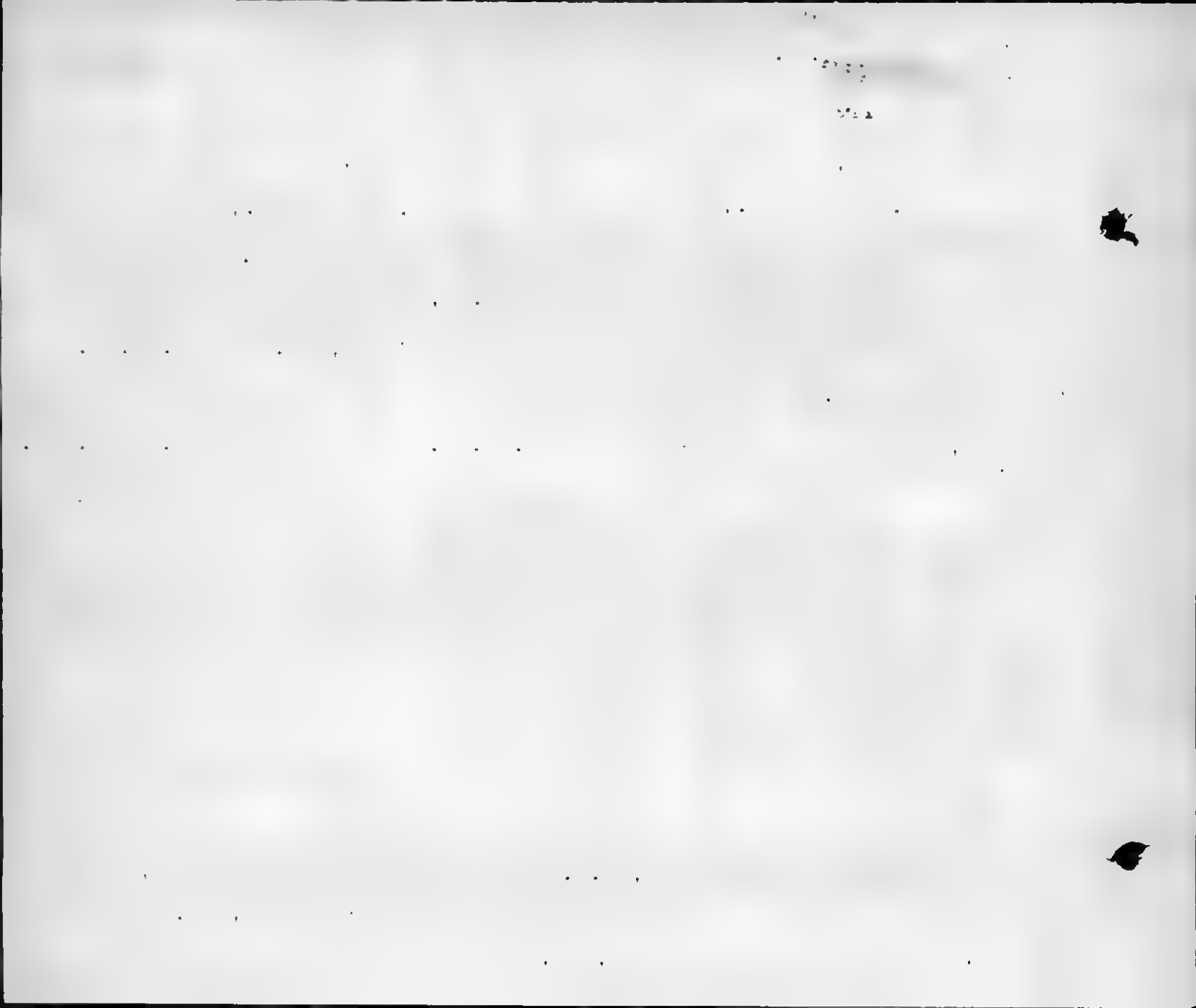
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10879**

10890

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 So. Spruce St.,				d. STREET ADDRESS 211 So. Spruce St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First JOHN Middle EARL Last DAVIS				4. DATE OF DEATH Month Oct. Day 30th Year 1960													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1903		9. AGE (In years last birthday) 57 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) North Branch, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.										
13. FATHER'S NAME Charles H. Davis				14. MOTHER'S MAIDEN NAME Nellie Virginia Twigg													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 217-10-7330		17. INFORMANT Address Mrs. A. H. Bloss Bowmans Add. Cumb. Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="width: 40%;"> INTERVAL BETWEEN ONSET AND DEATH SUDDEN --- </td> </tr> <tr> <td> (b) CORONARY SCLEROSIS DUE TO </td> <td></td> </tr> <tr> <td> (c) </td> <td></td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---	(b) CORONARY SCLEROSIS DUE TO		(c)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---																
(b) CORONARY SCLEROSIS DUE TO																	
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial				22b. DATE THEREOF 11/2/60		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.									
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 2 '60		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hines</i>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
IM 1/55

10941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 filed 10-13-60 et

Reg. Dist. No. 10880

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke, Md.		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) W. Va. Pulp & Paper Co.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 28	
4. NAME OF DECEASED (Type or print) First John Middle J. Last De Armye		4. DATE OF DEATH Month Oct. Day 9 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1915
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical En. ineer		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Windber, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mc Clellan De Armye		14. MOTHER'S MAIDEN NAME Mary Bossick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) War II		16. SOCIAL SECURITY NO. 206-07-2045	
17. INFORMANT George A. Farley, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 114.3 IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST DUE TO ELECTROCUTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4-5 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working with electric motor	
20c. TIME OF INJURY Month, Day, Year 7:45 a.m. Oct. 9 1960		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) W. Va. Pulp & Paper Luke		20f. (City or town) (County) (State) Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.D		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 9(9) 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-1960	
22c. NAME OF CEMETERY OR CREMATORY Richland Cemetery		22d. LOCATION (City, town, or county) (State) Richland, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

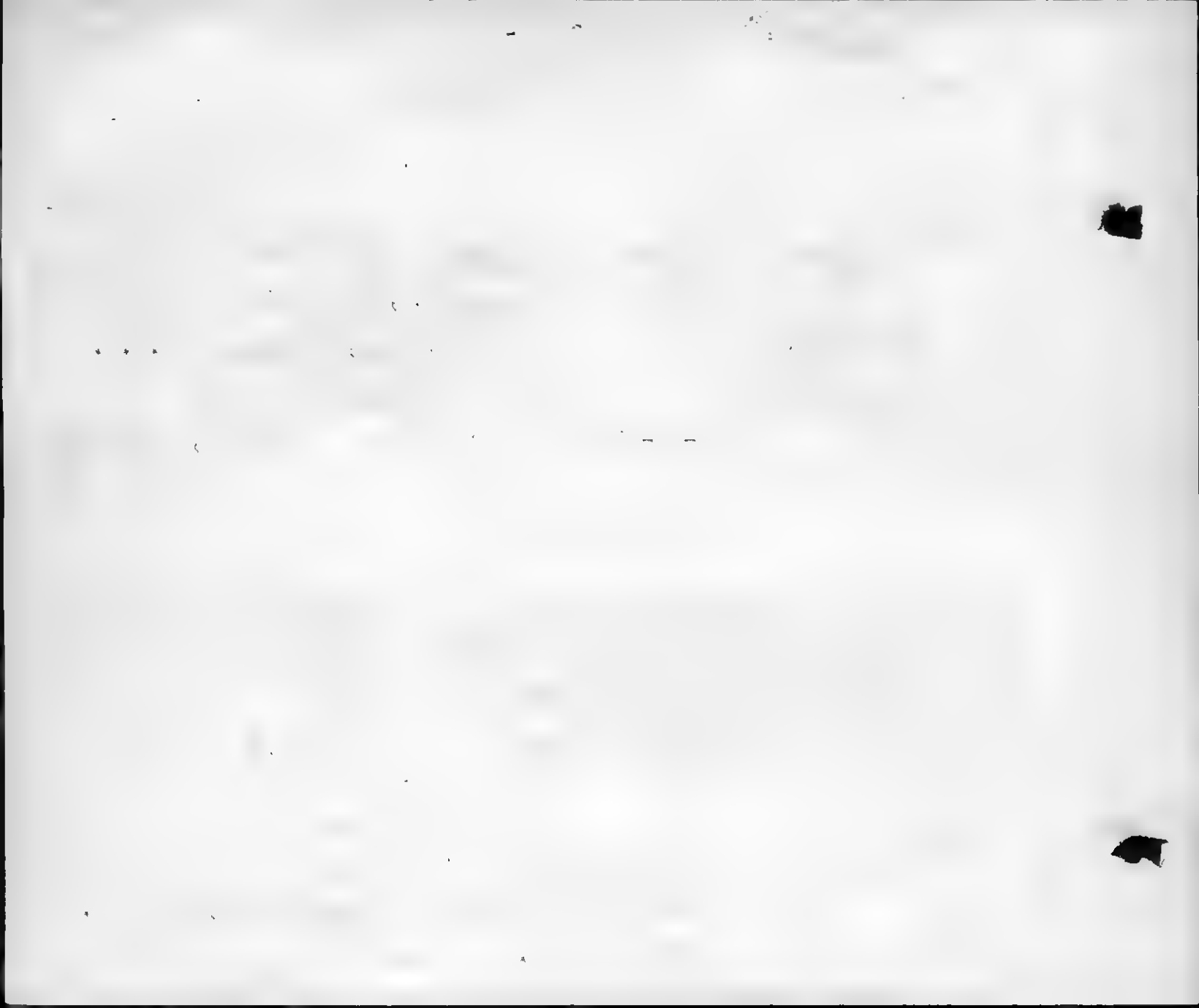
VR A15 (4)
15M 9/59

10942

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10882

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Archibald Dixon		4. DATE OF DEATH October 16, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1898
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Dixon		14. MOTHER'S MAIDEN NAME Ida Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-6079	
17. INFORMANT Mrs. Arch Dixon		Address Midland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 hours years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 13, 1960 to Oct 16, 1960 that (I) (we) last saw the deceased alive on Oct 5, 1960 , and that death occurred at 7 PM , from the causes and on the date stated above.			
22a. SIGNATURE L. R. Miles, M.D.		22b. DATE SIGNED 10-17-60	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.		22d. ADDRESS LONA CONING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/60	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumbarland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
25a. REC'D BY REGISTRAR OCT 19 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



(M)

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10931

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10883

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 10 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 74 Grant Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Andrew Middle J. Last Dunn				4. DATE OF DEATH Month October Day 21st Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9th, 1908	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Store Room		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh Dunn				14. MOTHER'S MAIDEN NAME Alice Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-07-6798		17. INFORMANT Mrs. Ursula C. Dunn, 74 Grant St., F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 5-1-0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month 10 Day 21 Year 1960 Hour 11 a.m. 11 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1927 to Oct 21, 1960 , that (I) (we) last saw the deceased alive on Oct 21, 1960 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				22b. DATE SIGNED Oct 24, 1960			
22c. PHYSICIAN'S NAME (Type) W. O. McLane				22d. ADDRESS 167 E. Main Street, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-25-60		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Christ				25a. REC'D BY REGISTRAR Oct 26 60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
ADDRESS Frostburg, Md.				DATE			



may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

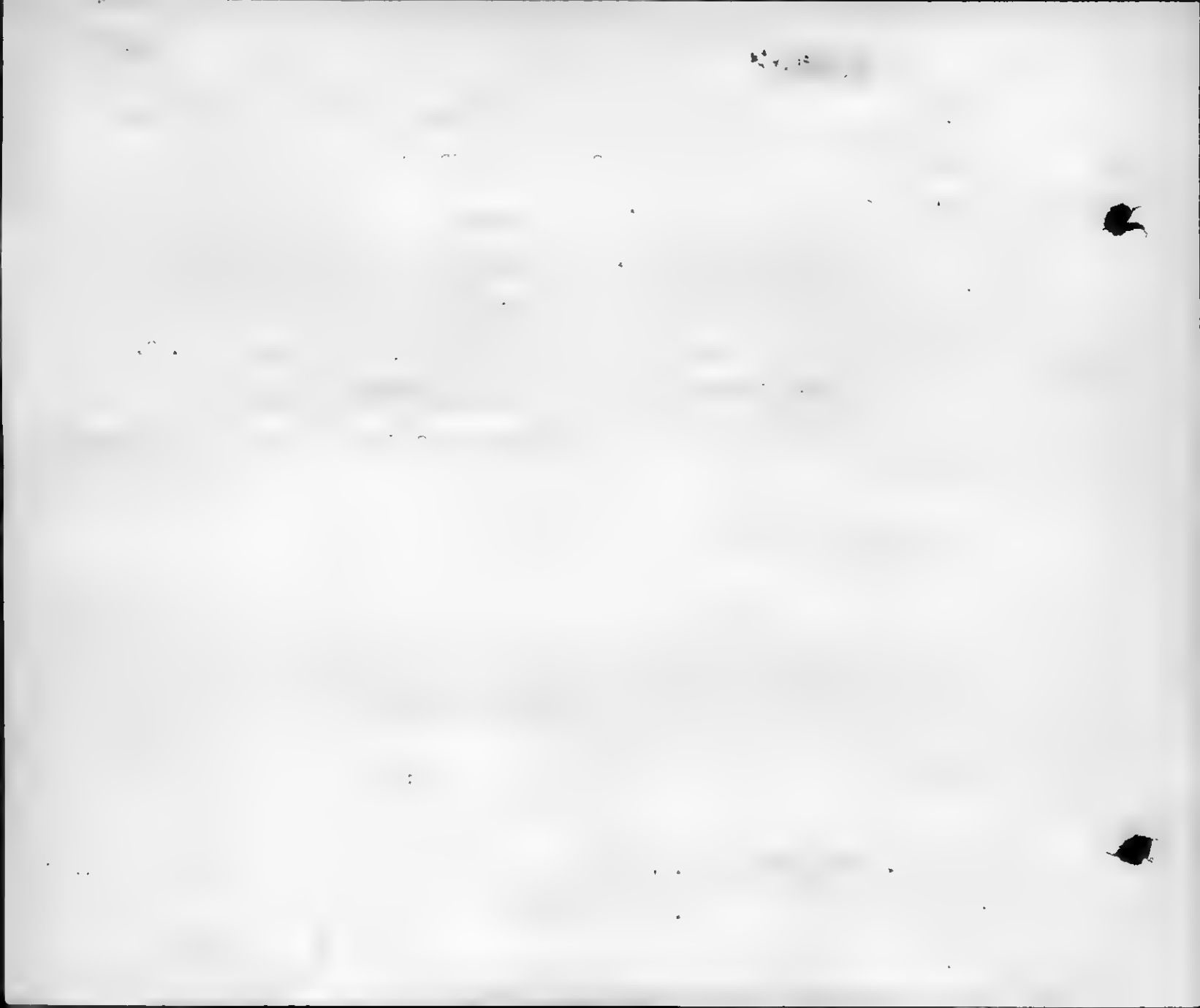
10891

10884

10891

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 119 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AMANDA A. DU VALL				4. DATE OF DEATH Month Day Year OCTOBER 5 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 11	
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) MARYLAND, Spring Gap				12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA			
13. FATHER'S NAME GEORGE GARLAND				14. MOTHER'S MAIDEN NAME ELIZABETH DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. None			
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancreatic cancer DUE TO (c) if any							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1955 to Oct 5 , 1960, that (I) (we) last saw the deceased alive on Oct 5 , 1960, and that death occurred at 6:45 PM on the causes and on the date stated above							
22a. SIGNATURE DR. DONALD GROVE				22b. DATE SIGNED 10-7-60			
22c. PHYSICIAN'S NAME (Type) DR. DONALD GROVE				22d. ADDRESS 122 S. C. H. St. C. H. St. C. H. St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		23d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE OCT 10 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



10932

CERTIFICATE OF DEATH

10885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>33 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Miners</u>		d. STREET ADDRESS <u>Miners Hospital</u>	
3. NAME OF DECEASED (Type or print) First <u>Jammy</u> Middle <u>Theresa</u> Last <u>Emmatt</u>		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-60</u>
9. AGE (In years last birthday) yrs. <u>33</u>		10. IF UNDER 1 YEAR: Months <u>33</u> Days <u>33</u> Hours <u>33</u> Min <u>33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Bruce Emmatt</u>		14. MOTHER'S MAIDEN NAME <u>Harriett K. Holsinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Robert Bruce Emmatt, Frostburg, Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth</u> 61.5 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>33 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Premature separation of placenta</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-2</u> , 19 <u>60</u> , to <u>10-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>60</u> , and that death occurred at <u>4</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.C. Diehl</u> M.D.		ADDRESS (Street, city or town, state) <u>39 W. Main St. Frostburg, Ind.</u>	
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>		DATE SIGNED <u>10/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. H. Barrett</u> ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

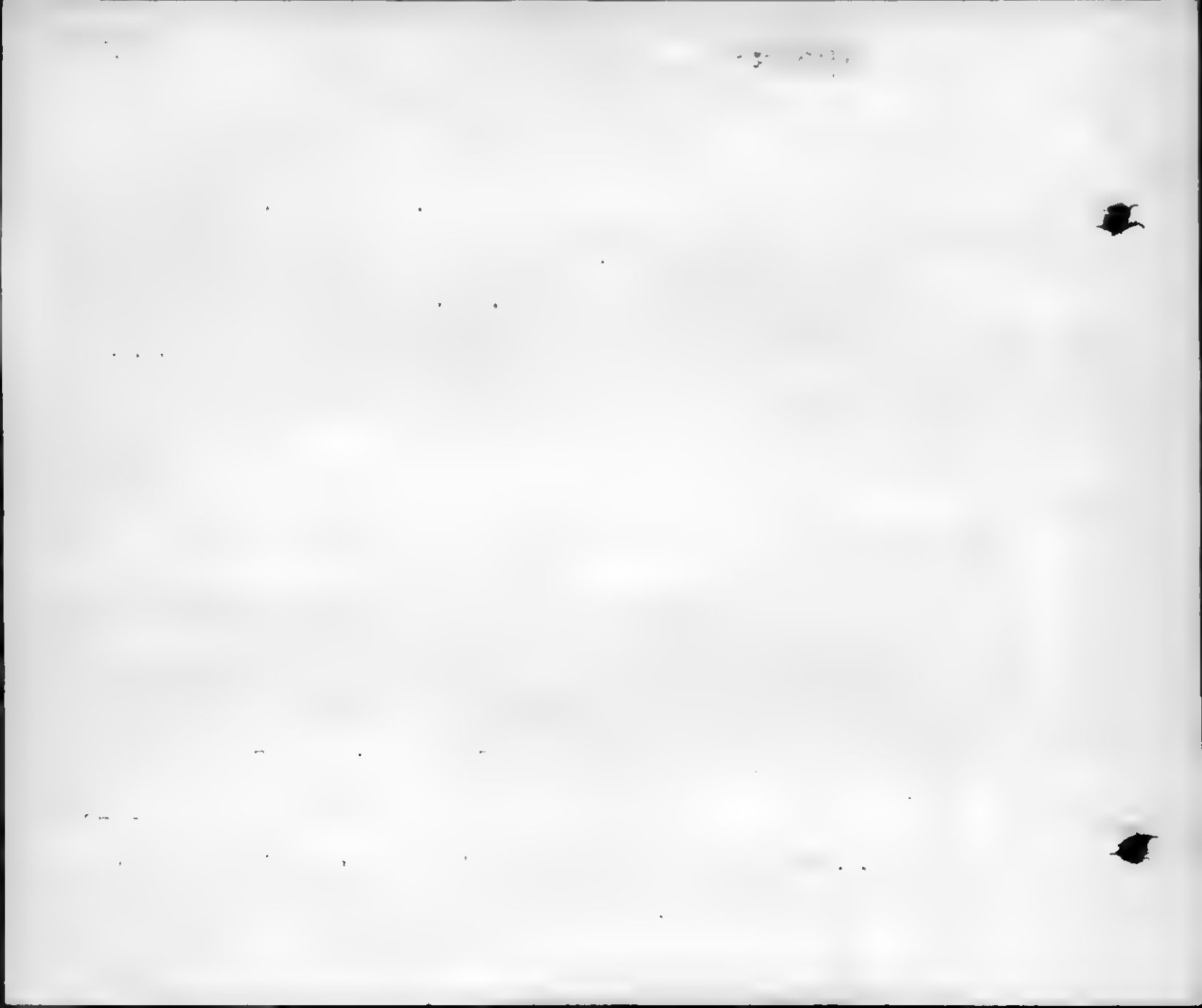
10892

CERTIFICATE OF DEATH

10886

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 1/2 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				d. STREET ADDRESS 112 N. SMALLWOOD ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First ETLA Middle L. Last FISHER		4. DATE OF DEATH		Month October Day 3 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1879		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) MARYLAND-CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK LAVIN				14. MOTHER'S MAIDEN NAME Mary Brannen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic and hypertensive cardiovascular disease DUE TO (c) vascular disease							INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-2-1960 to 10-3-1960 that (I) (we) last saw the deceased alive on 10-2-1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Reg. L. Ballin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-3-60	
22c. PHYSICIAN'S NAME (Type) Dr. R. Ballin				22d. ADDRESS 62 Greene St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-1960		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery Cumberland, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR OCT 5 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10937

CERTIFICATE OF DEATH

10887

Reg. Dist. No.

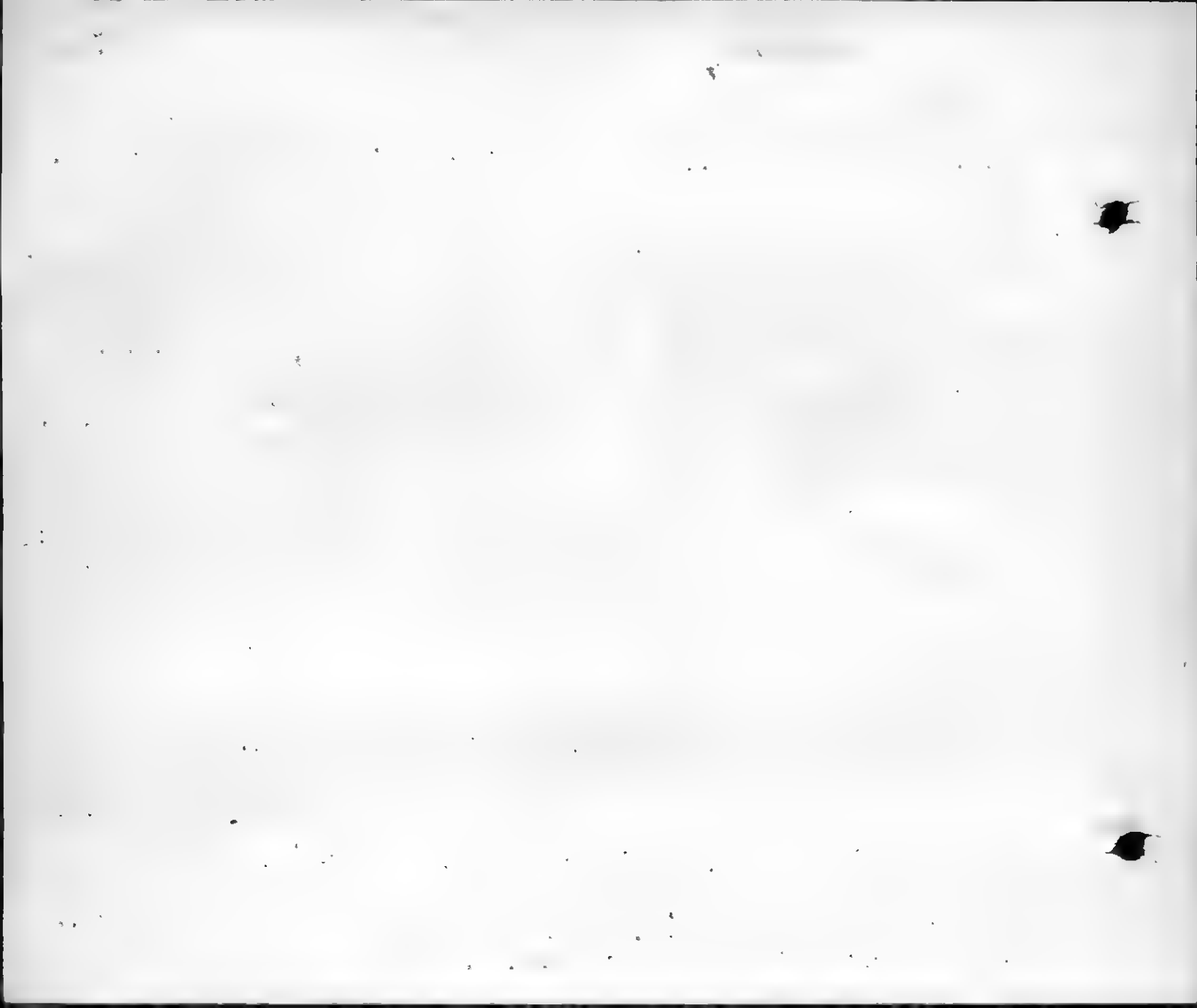
1. PLACE OF DEATH a. COUNTY Alleganey MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Alleganey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 4Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Potomac St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle M. Greenan Last		4. DATE OF DEATH Month Oct Day 7 Year 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4. 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Hancock, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Murray		14. MOTHER'S MAIDEN NAME Mary Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Ann Murray		Address Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1958, to Oct. 6, 1960 , that I last saw the deceased alive on October 6, 1960 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, West Va. DATE SIGNED 10/7/60			
ACTUAL SIGNATURE James H. Wolverton, Sr. PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY St Peters Cemetery		22d. LOCATION (City, town, or county) (State) Hancock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Harold Fredlock, Piedmont W. Va.		24a. REC'D BY REGISTRAR DATE OCT 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



10943 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 7 Film G274 11-4-60 et
 CERTIFICATE OF DEATH

Reg. Dist. No. 10888

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. #2, Frostburg, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. #2, Box 82, Frostburg, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle HAYES Last HARRIS				4. DATE OF DEATH Month 10 Day 29 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1893		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 6 Days 7	IF UNDER 24 HRS Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Midlothian, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Price Hayes				14. MOTHER'S MAIDEN NAME Lydia Winebrenner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Arthur Harris, R.D. #2, Box 88, Frostburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arterio-sclerotic cardio-vascular disease DUE TO (b) 1 1/2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10, 1960 , to 10-29, 1960 , that I last saw the deceased alive on 10-28, 1960 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl		M.D.		ADDRESS (Street, city or town, state) 39 W. Main St. Frostburg, Md.		DATE SIGNED 10/31/60	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/60		22c. NAME OF CEMETERY OR CREMATORY Percy Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montague				24a. REC'D BY REGISTRAR NOV 2 '60		24b. REGISTRAR'S SIGNATURE Charles E. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)
15M 9/59

10933

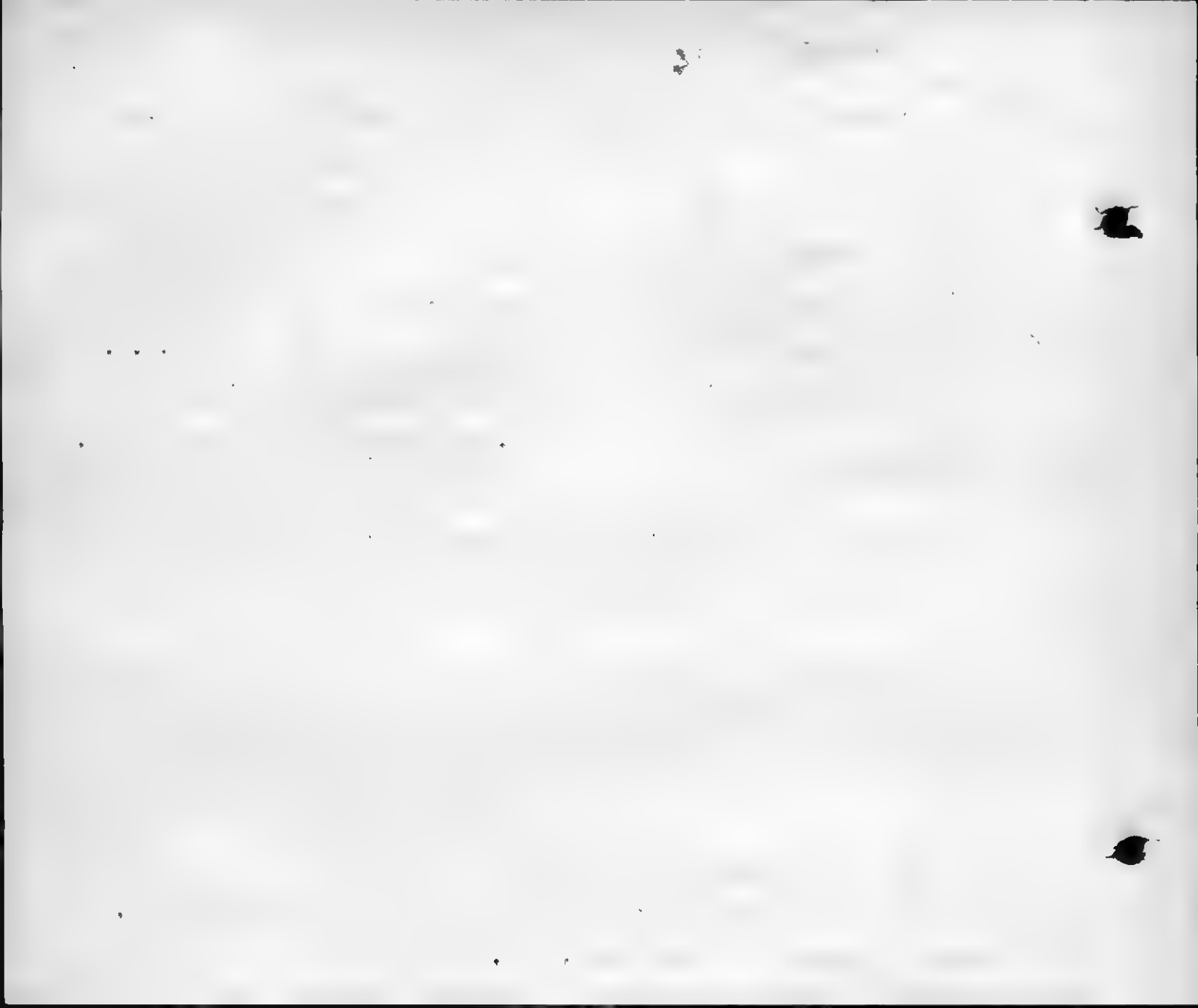
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10889

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Harris				4. DATE OF DEATH Month Day Year October 23 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1886	
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Business Man				10b. KIND OF BUSINESS OR INDUSTRY Meat Market		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Harris				14. MOTHER'S MAIDEN NAME Elizabeth Prichard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-32-3161A			
17. INFORMANT Mrs. Boyd Bolyard				Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction 422.1 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO years							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Sepsis secondary for intestinal obstruction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 3, 1956 to Oct. 23, 1960 that (I) (we) last saw the deceased alive on Oct. 23, 1960 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE L.R. Miles, Jr. M.D.				22b. ADDRESS LONACONING MD.		22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/60		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.				25a. REC'D BY REGISTRAR OCT 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

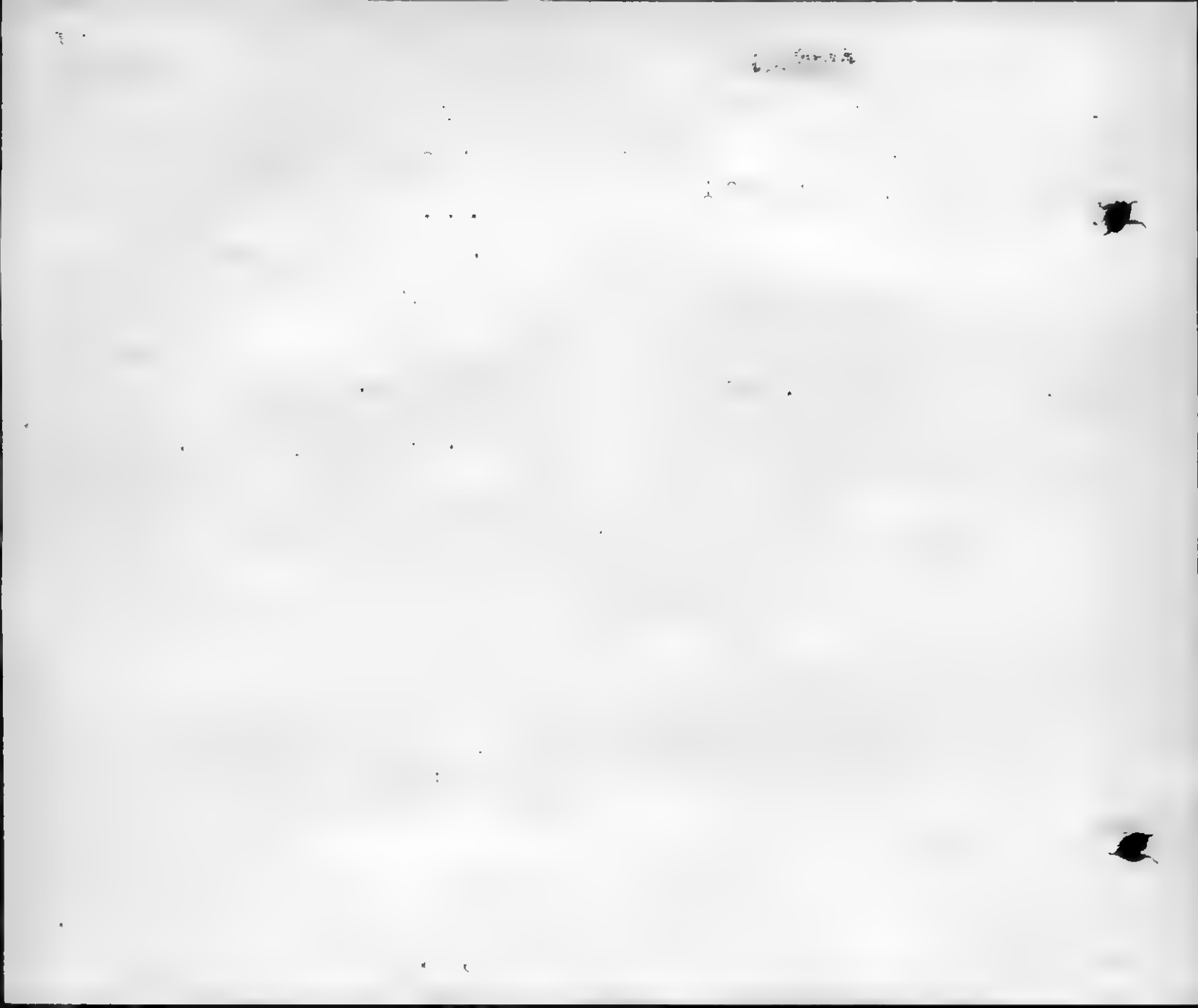
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10893

10890

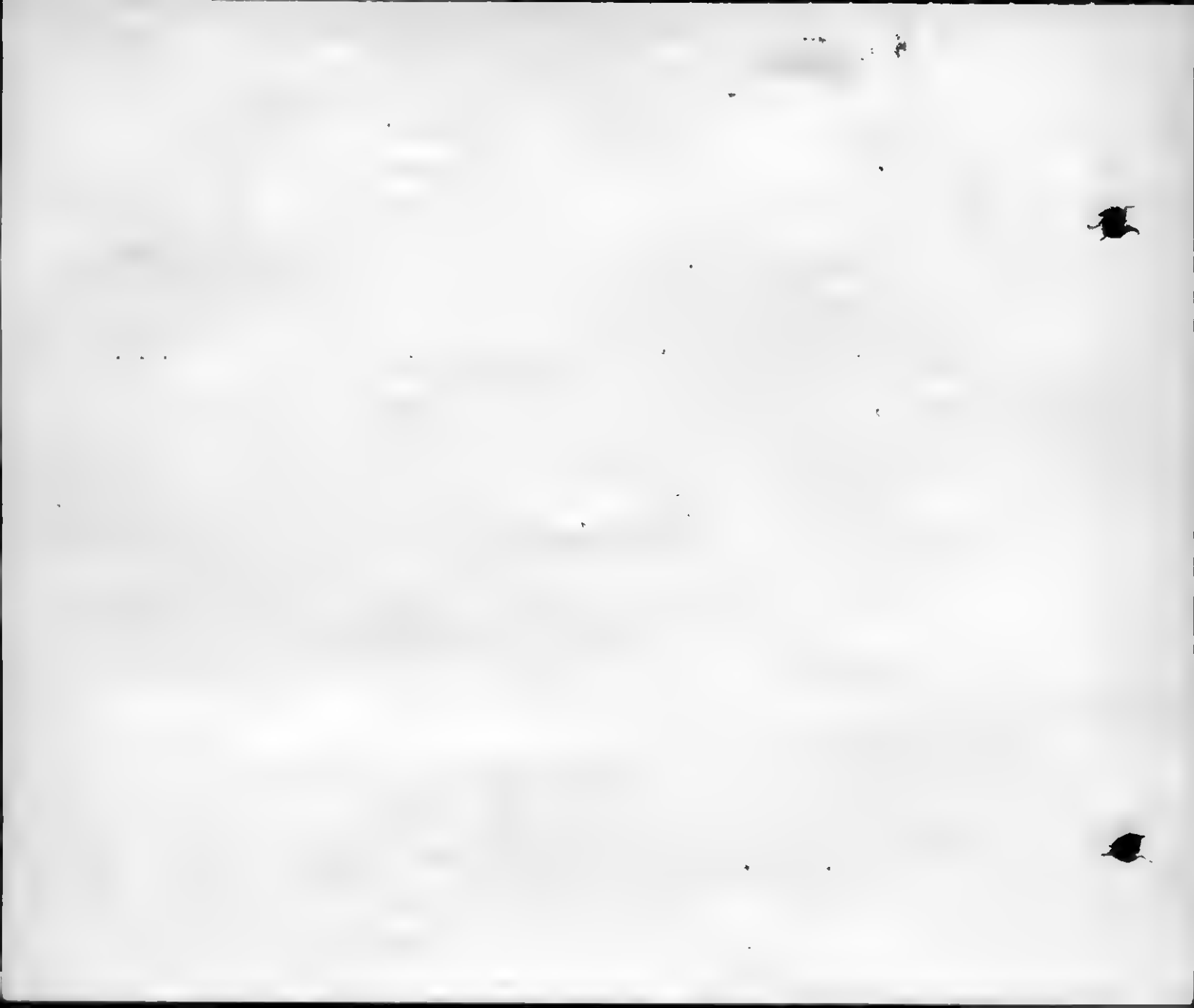
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOYCE Middle LEE Last HOUSE		4. DATE OF DEATH Month OCTOBER Day 8 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 4, 1960
9. AGE (In years last birthday) yrs 4		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE P. HOUSE		14. MOTHER'S MAIDEN NAME DORIS ARNOLD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT (Father) George P. House, Harris Apts.,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Blotches + DUE TO Heart Failure (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred 9:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-60	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		25a. REC'D BY REGISTRAR 23 East Main, Frostburg, Md.	
25b. REGISTRAR'S SIGNATURE [Signature]		OCT 14 '60	



10894
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10891

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 60yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle B. Last Hymes				4. DATE OF DEATH Month October Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/97	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Postal		10b. KIND OF BUSINESS OR INDUSTRY Transportation Serv		11. BIRTHPLACE (State or foreign country) Maryland Flintstone		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Hymes (D)				14. MOTHER'S MAIDEN NAME Matilda Smith (D)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 213-40-3590		17. INFORMANT Irene Isabelle Hymes		Address 128 Monroe St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hepatic coma						1 year	
DUE TO (b) liver cirrhosis							
DUE TO (c) lyng cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE L. Brings		M.D. <input checked="" type="checkbox"/>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 10-27-60	
22c. PHYSICIAN'S NAME (Type) L. Brings		22d. ADDRESS 57 Greene St. Cumberland Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-24-60	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City, town, or county) (State) Cumberland, d.				
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 26 '60	25b. REGISTRAR'S SIGNATURE C. H. S. Hume	



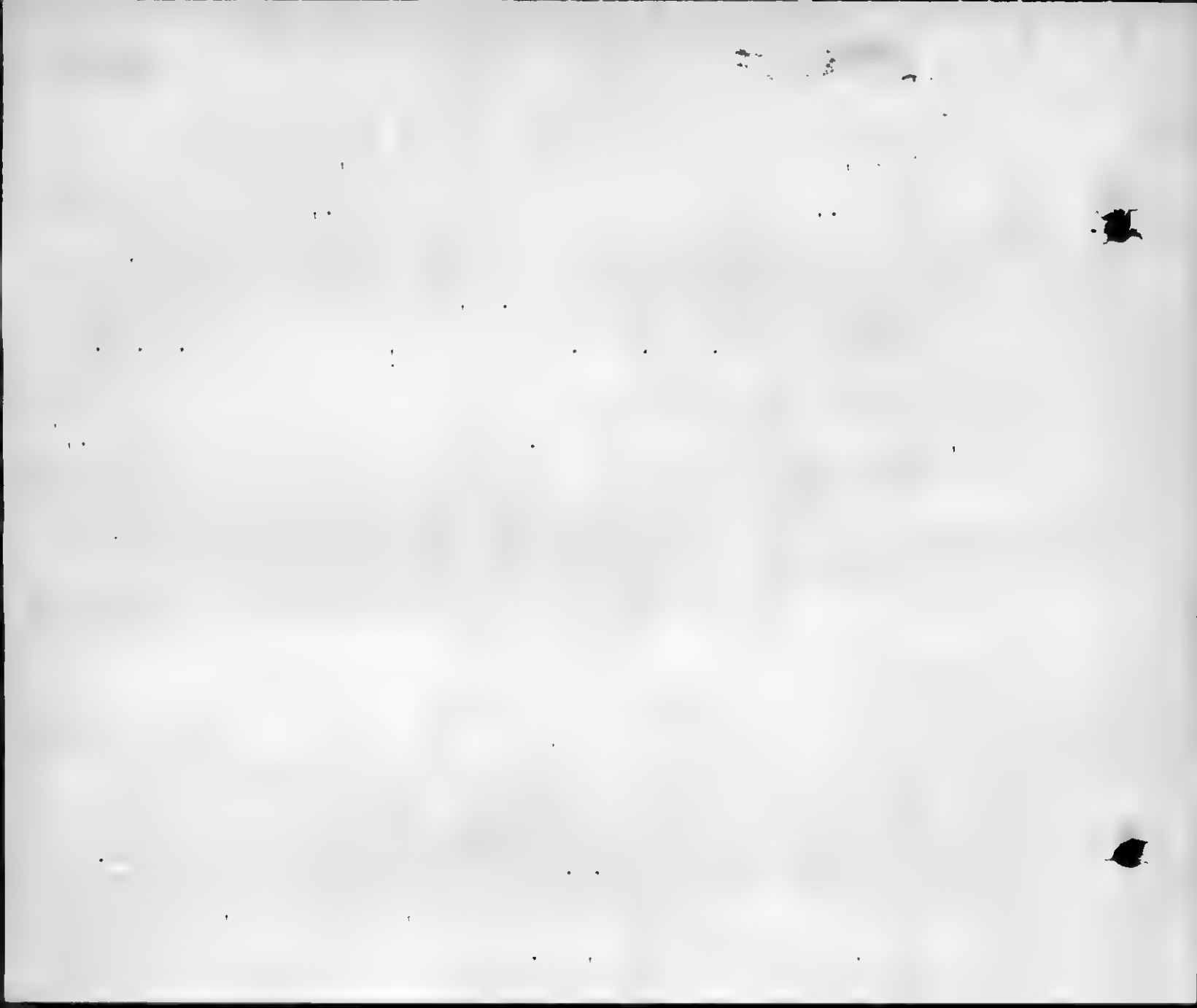
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

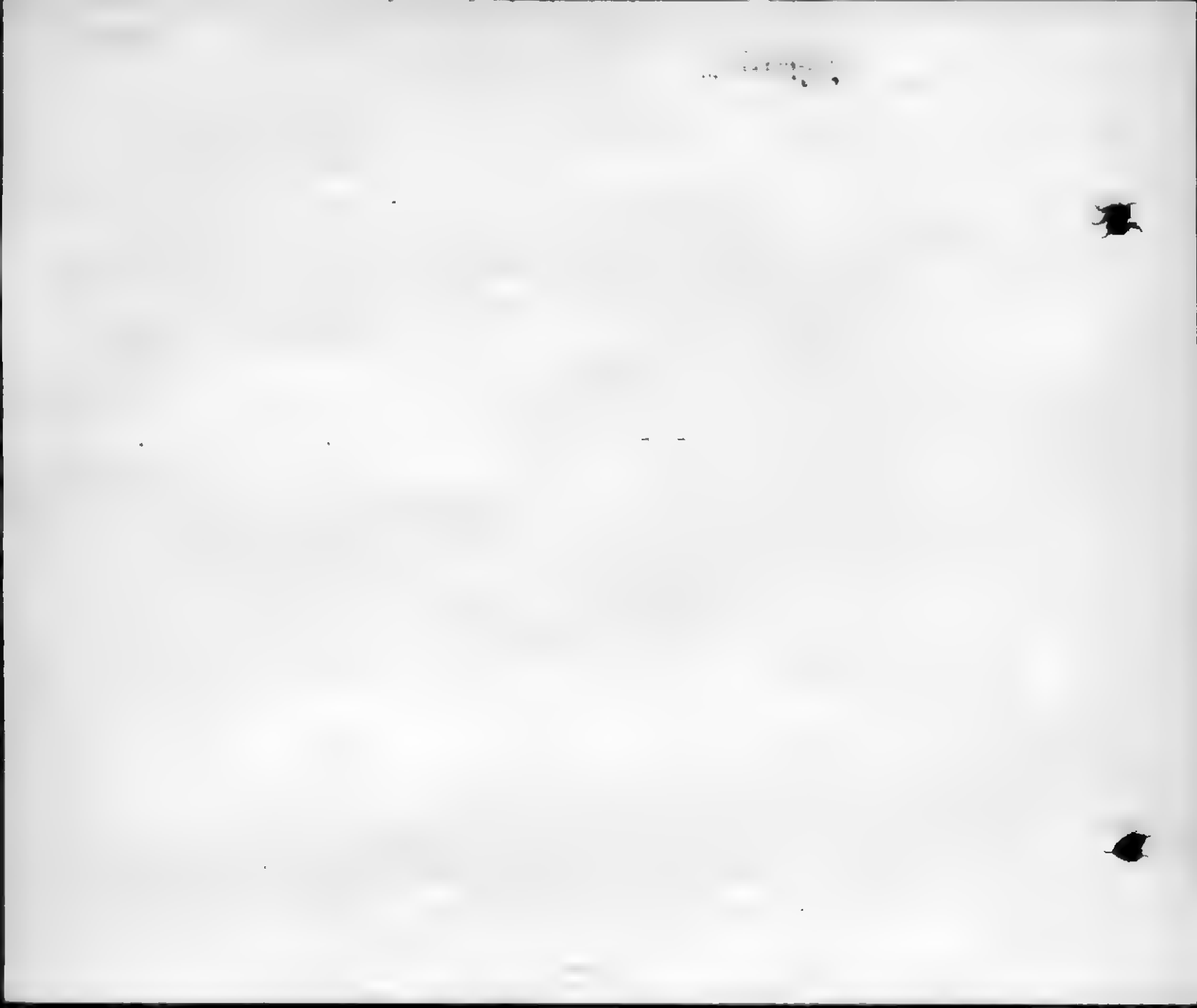
Reg. Dist. No. **10892**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 149 Polk St.,				d. STREET ADDRESS / 149 Polk St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorsey Middle Edward Last Jefferys				4. DATE OF DEATH Month October Day 11 , Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1897		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Train Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) Altamont, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alfred Jefferys				14. MOTHER'S MAIDEN NAME Gertrude Warnick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Cumberland, Md Mrs. Catherine Jefferys 149 Polk St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH Sudden ----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12 Oct. 60	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/60		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 17 '60 DATE	
				24b. REGISTRAR'S SIGNATURE Cuthbert L. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
108936									
10893									
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 436 Park Street					d. STREET ADDRESS 436 Park Street				
3. NAME OF DECEASED (Type or print) First Joseph Middle Asbury Last Johnson					4. DATE OF DEATH Month October Day 22 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11 1884		9. AGE (In years last birthday) 76 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitor			10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Levels, West Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Johnson					14. MOTHER'S MAIDEN NAME Elizabeth Largent				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 217-10-6447A		17. INFORMANT Mrs. Catherine Gall, Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Seminal arteriole (c) Arteriole PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 years								INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 15 1960 to Oct 22 1960 , that (I) (we) last saw the deceased alive on Oct 15 1960 , and that death occurred at 10/22/60 from the causes and on the date stated above.									
22a. SIGNATURE B. M. Schindler					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/22/60		
22c. PHYSICIAN'S NAME (Type) B. M. SCHINDLER					22d. ADDRESS Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF OCT. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight					ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume



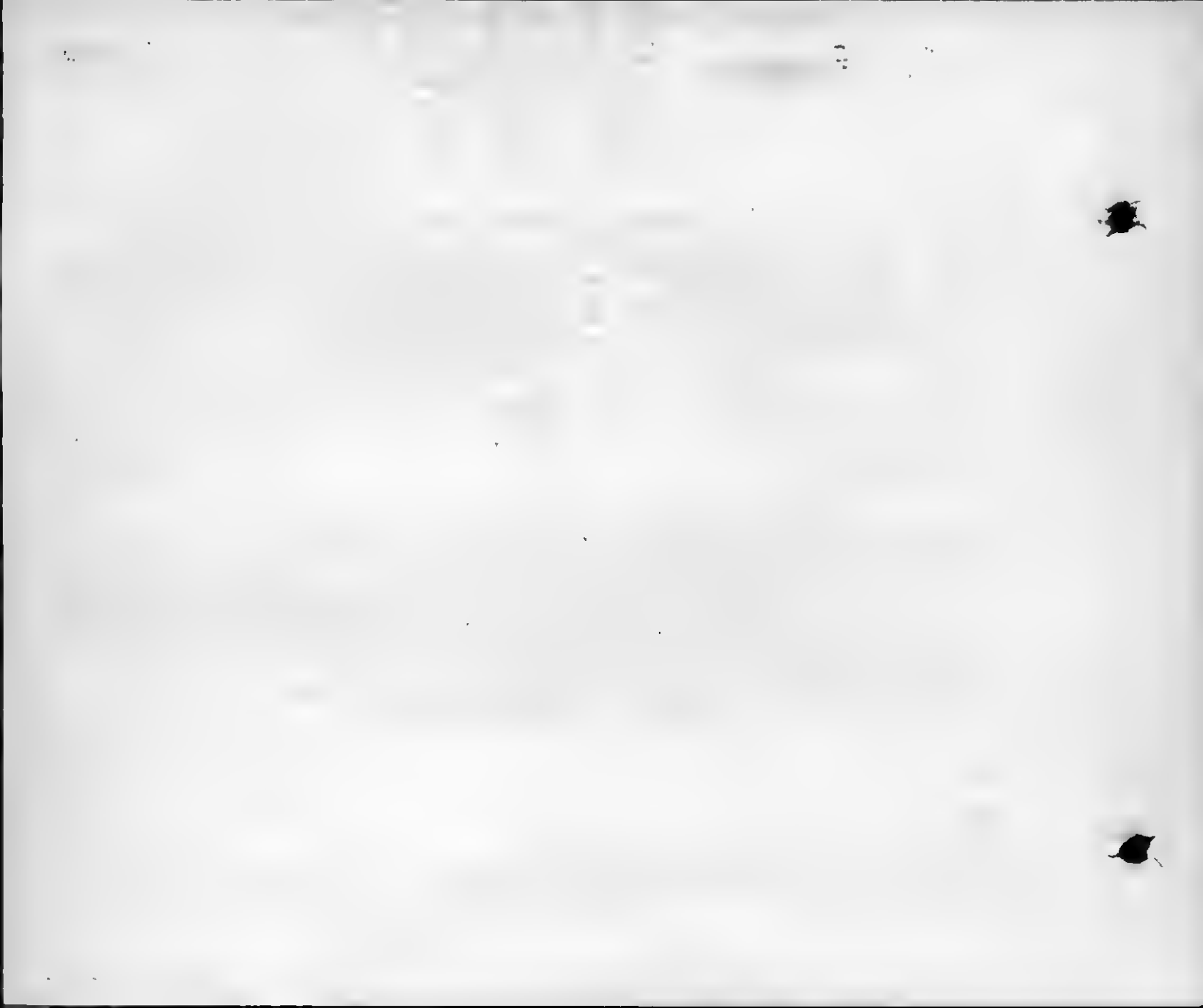
CERTIFICATE OF DEATH

Reg. Dist. No. 10894

10897

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1214 Lafayette Ave.		e. STREET ADDRESS 1214 Lafayette Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle Snyder Last Johnson		4. DATE OF DEATH Month Oct. Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1882
9 AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Ice & Fuel Co.	
11. BIRTHPLACE (State or foreign country) Lockhaven, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Drell Johnson		14. MOTHER'S MAIDEN NAME Alice Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-7163	
17 INFORMANT Mrs. Joseph Snyder, Cumberland, Md.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive old Rt foot		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/11 , 19 60 to 10/23 , 19 60 , that I last saw the deceased alive on Sept , 19 60 , and that death occurred at 11:20 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. G. WEISMAN M.D.		ADDRESS (Street, city or town, state) 59 GREENE ST DATE SIGNED 10/25/60	
PHYSICIAN'S NAME (Type) S. G. WEISMAN MD		CUMBERLAND, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-1960	
22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery		22d. LOCATION (City, town, or county) (State) Ridgeley, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 31 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles J. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10945

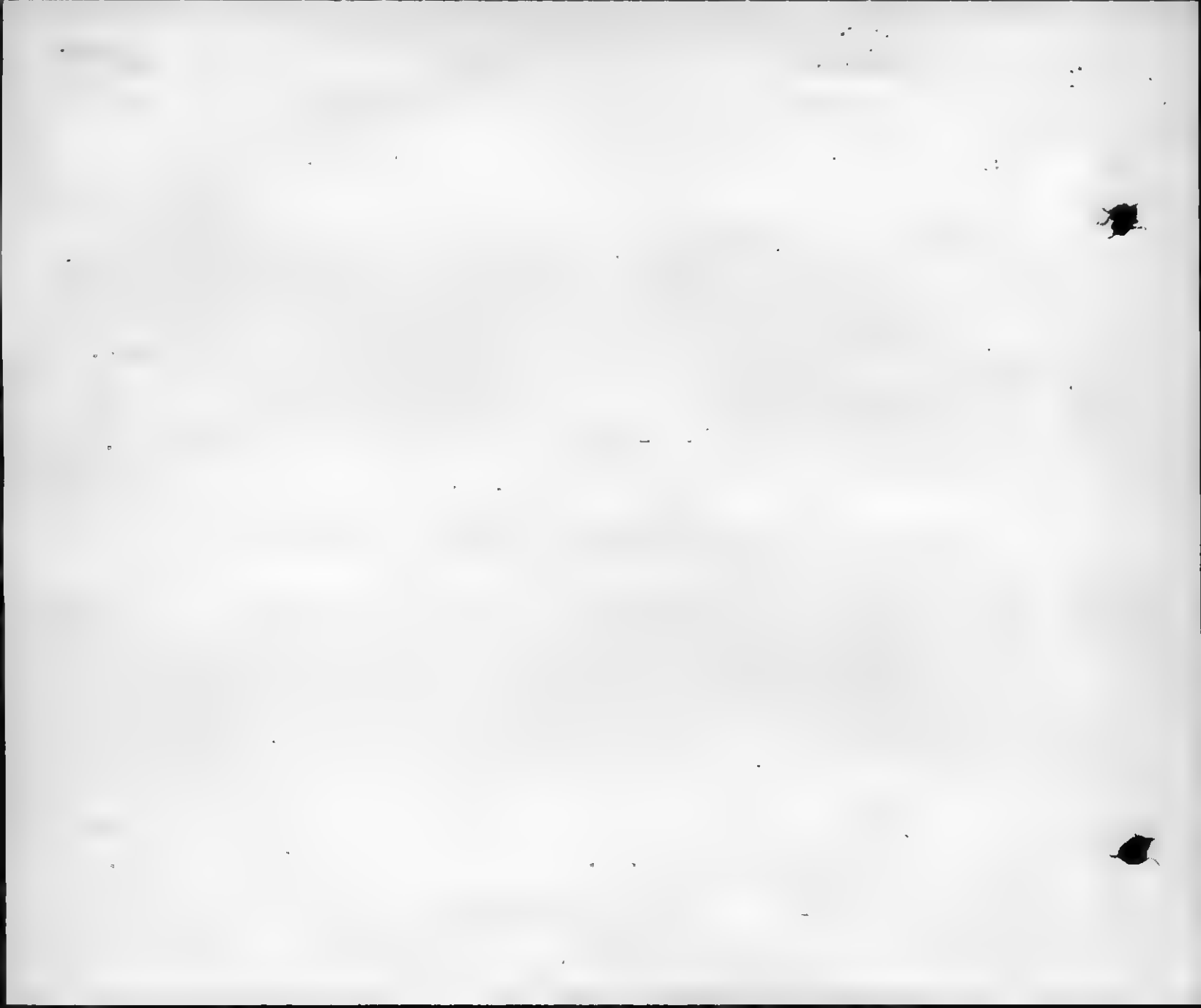
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10895

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - FROSTBURG				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG - RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle B. Last KALLMYER				4. DATE OF DEATH Month OCTOBER Day 5 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 20, 1893		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min 67	11. IF UNDER 24 HRS Months 67 Days 67 Hours 67 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SOMMERKAMP				14. MOTHER'S MAIDEN NAME EMMA SNYDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-01-3768A		17. INFORMANT HAROLD KALLMYER, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7-20-1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO years (c) 24 hrs.				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 60 to Oct 3 19 60 that (I) last saw the deceased alive on Oct. 3 19 60 and that death occurred at 4 AM , from the causes and on the date stated above.							
22a. SIGNATURE John B. Davis,				22b. DATE SIGNED 10/7/60		22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.	
22d. ADDRESS BROADWAY, FROSTBURG, MD.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-8-60		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City, town, or county) (State) ECKHART, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE L. P. ...				25a. REC'D BY REGISTRAR DATE OCT 10 '60		25b. REGISTRAR'S SIGNATURE William B. ...	
ADDRESS FROSTBURG, MD.							

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1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

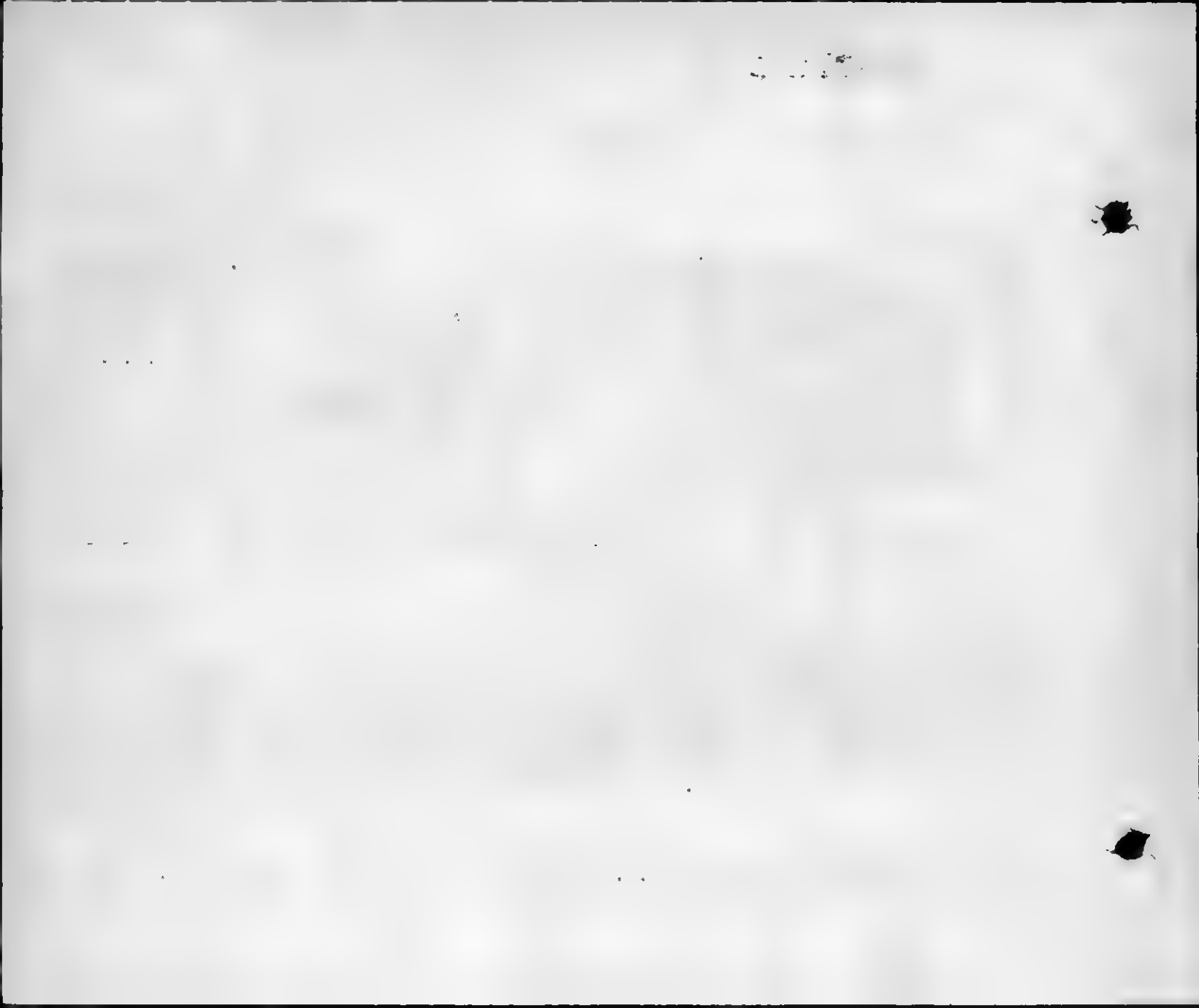
Reg. Dist. No.

10897

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARRELSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Pearl</u> Last <u>KELLY</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTOPHER O. BAKER</u>				14. MOTHER'S MAIDEN NAME <u>ELLA MC CRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>SON of Edward E Kelly Mt Savage Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarulic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>OCTOBER 8, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc. Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar for a burial, cremation, or removal.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10899

10898

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>01 CUMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>208 N CENTER STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TIMOTHY</u> Middle <u>L.</u> Last <u>KENNY</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/77</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brick Works Mt Savage, Maryland</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				13. FATHER'S NAME <u>EDWARD KENNY</u>			
14. MOTHER'S MAIDEN NAME <u>MARY ANN KENNY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>60</u> , to <u>10/27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> , 19 <u>60</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Geo H. Hey</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. H. LEY</u>				22d. ADDRESS <u>456 N CENTER STREET</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Patrick's Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Mt Savage, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>				ADDRESS <u>Cumbr. Md</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10899

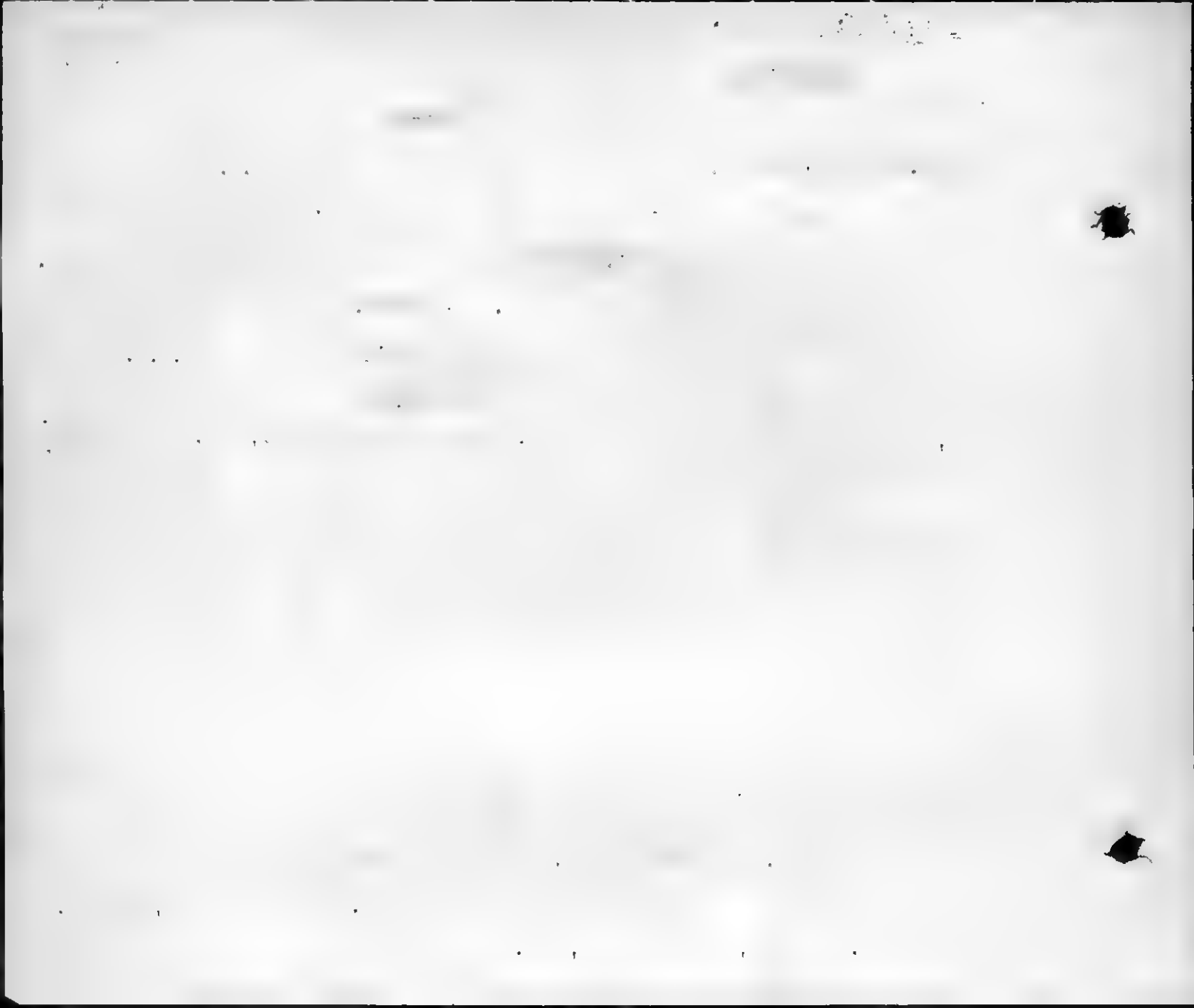
10900

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOTTIE Middle May Last Kifer				4. DATE OF DEATH Month OCTOBER Day 28 Year 1960			
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 7th, 1884		9 AGE (In years and birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11 BIRTHPLACE (State or foreign country) Polish Mt. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MCCOY				14. MOTHER'S MAIDEN NAME Lucy Smith			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Marion Nesselrodt, Rt. #1 Flintston			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary heart disease 260 DUE TO diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized arteriosclerosis (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 years years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction 5 yr. ago Miniplegia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1952 to 10/28 19 60 , that (I) (we) last saw the deceased alive on 10/28 19 60 , and that death occurred at 8 P. M. from the causes and on the date stated above							
22a. SIGNATURE Elizabeth Brings				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/29/60	
22c. PHYSICIAN'S NAME (Type) Dr. ELIZABETH BRINGS.				22d. ADDRESS 55 Greene St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60		23c. NAME OF CEMETERY OR CREMATORY Prosperity Cemetery		23d. LOCATION (City, town, or county) (State) Nr. Chaneyville, Penna.	
24 FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a REC'D BY REGISTRAR NOV 1 '60		25b REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

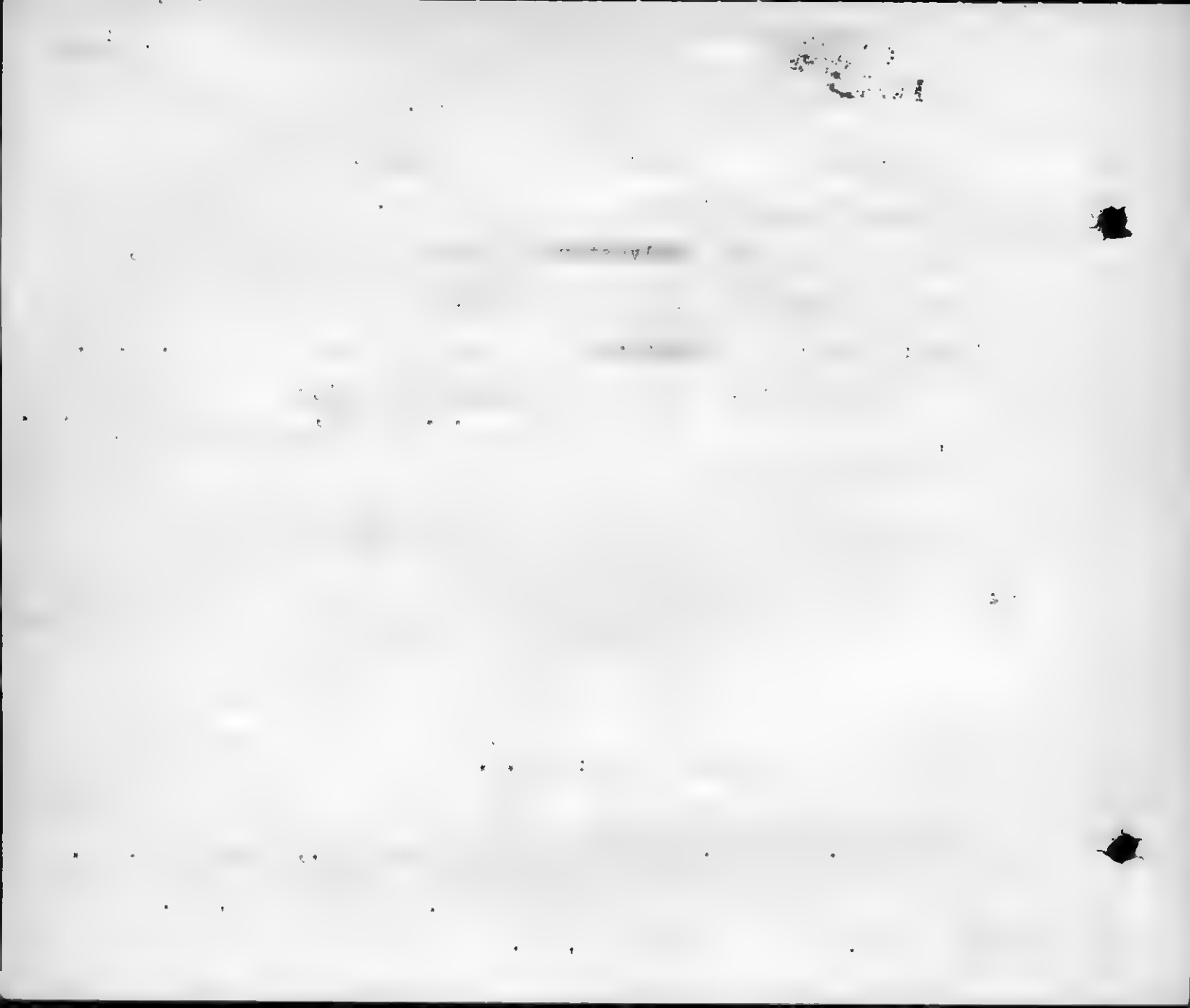
109001

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10900

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10/2/60		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				f. STREET ADDRESS Along Rt. # 51		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle Selvester Last Kline				4. DATE OF DEATH Month October Day 11, Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1879		9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Kline				14. MOTHER'S MAIDEN NAME Catherine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO Cerebral arteriosclerosis (b) Chronic Nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spontaneous Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/2/60 19 to 10/11/60 19, that (I) (we) last saw the deceased alive on 10/11/60 19, and that death occurred at 5:55 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE James E. McLean				22b. DATE SIGNED 10/12/60		22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22d. ADDRESS 49 Greene St., Cumberland, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/60		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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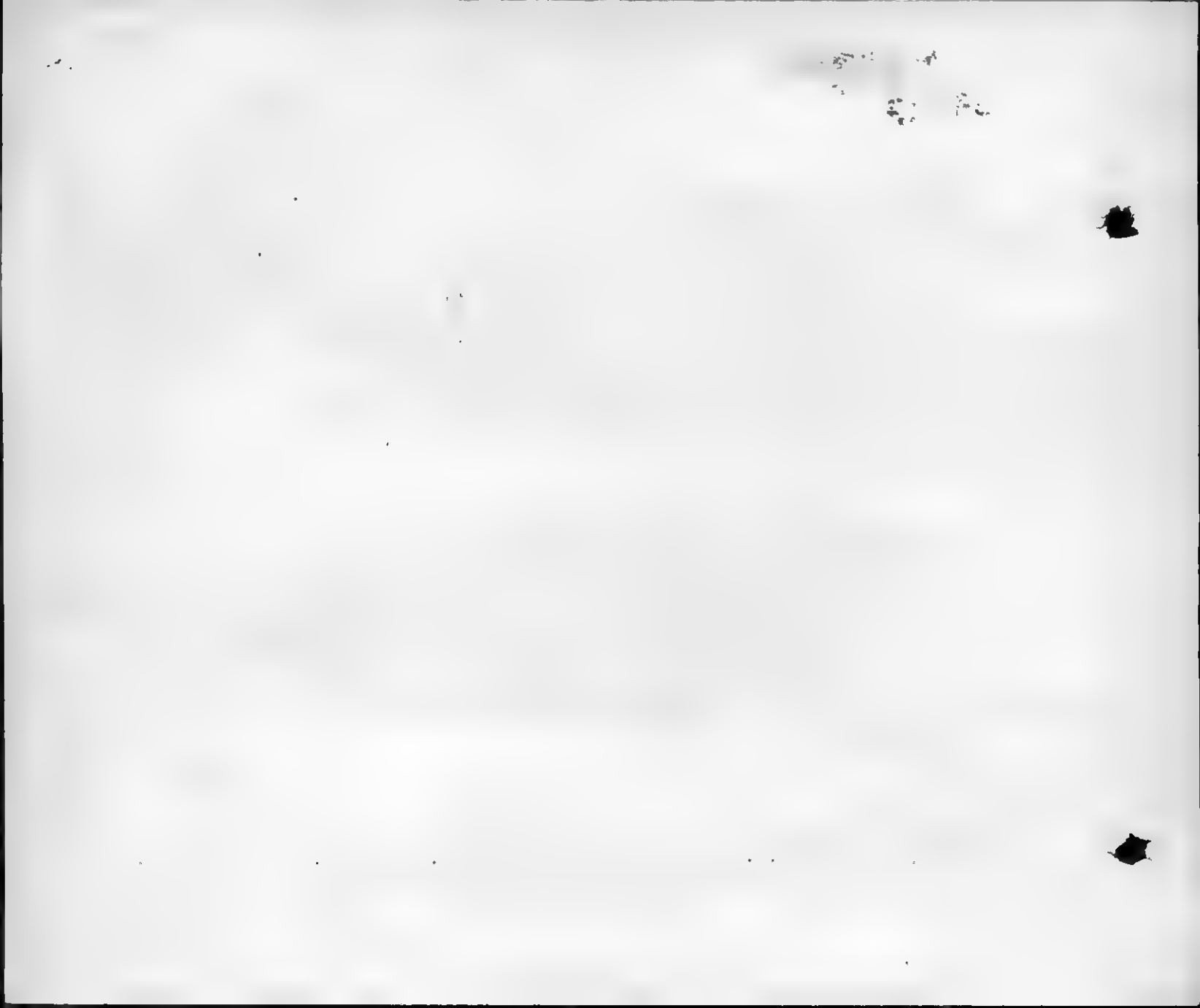
CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10901

10902

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 45 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) SACRED HEART HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02. CUMBERLAND			
f. STREET ADDRESS 1 138 BEDFORD ST.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First TENNIE Middle C Last KLINE				4. DATE OF DEATH Month OCT. Day 27 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 20 1882	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min 10		11. IF UNDER 24 HRS Hours 10 Min 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME WILLIAM YOST (DECEASED)				14. MOTHER'S MAIDEN NAME JENNIE Hobday			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. PATIENTS CHART.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9/11 19 60 to 10/27 19 60 , that (I) (we) last saw the deceased alive on 10/27 19 60 , and that death occurred at 2:30 P. from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley, Jr.				22b. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.		22c. PHYSICIAN'S NAME (Type) LEO H. LEY, JR., M.D.	
22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.		22e. DATE 10/28/60		22f. SIGNED 10/28/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				25a. REC'D BY REGISTRAR DATE OCT 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10903

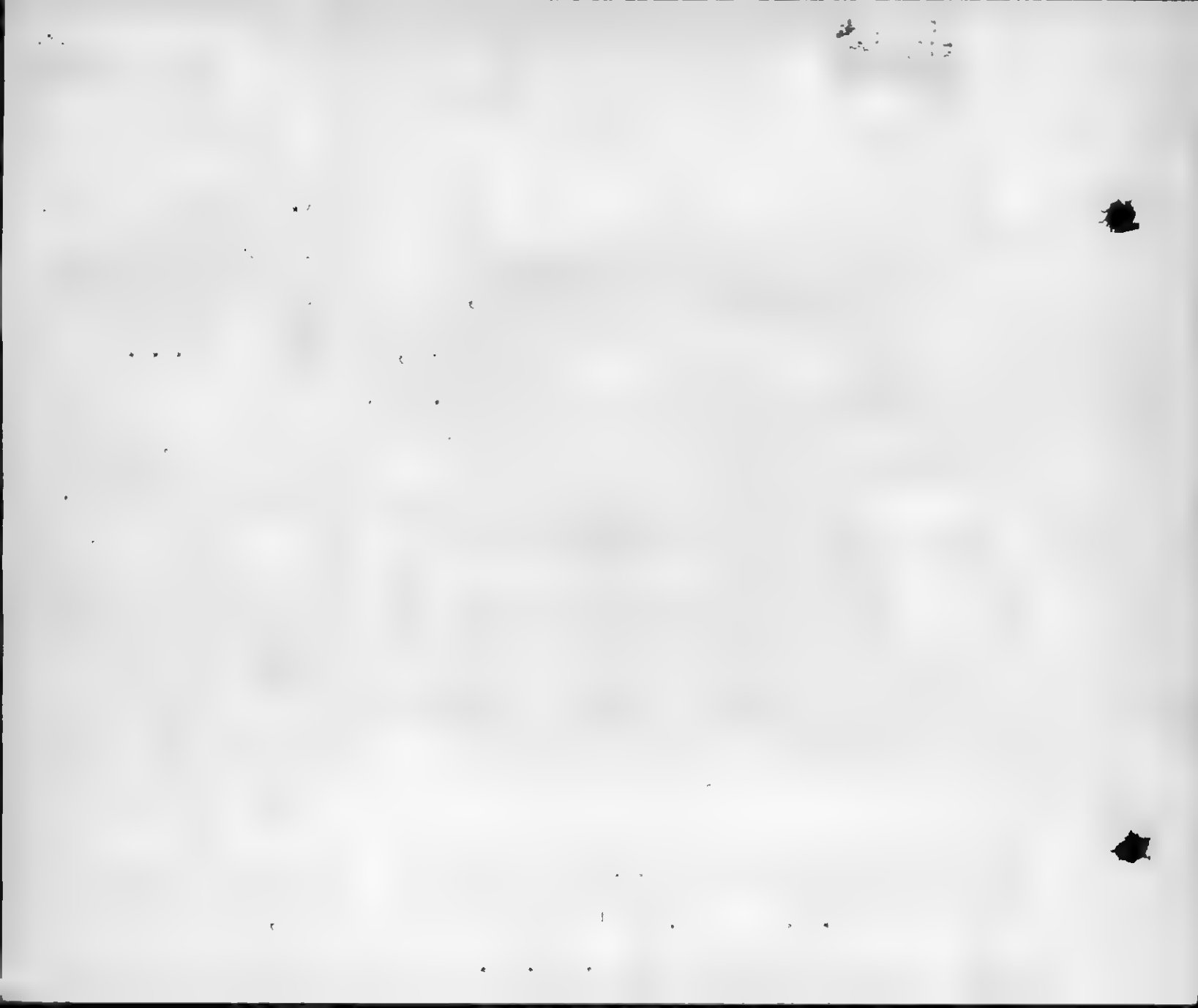
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10902

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 135 Bedford St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Margaret Last Knieriem				4. DATE OF DEATH Month October Day 27 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 22, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gustave Knieriem				14. MOTHER'S MAIDEN NAME Edith M. Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Gustave Knieriem				Address Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA, CARDIAC DECOMPENSATION DUE TO Conditions, if any, which gave rise to immediate cause (b) CHRONIC MYOCARDITIS (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 0 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED October 27, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS 117 Frederick St. Cumb. Md.		24a. REC'D BY REGISTRAR DATE OCT 31 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Hines			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(9)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10903

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rawlings</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route Oakland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>11X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathaniel DANIEL KNOX</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>7</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1919</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathaniel Knox</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Knox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes (unk.)</u>		17. INFORMANT Address <u>Mrs. Paul Friend Swanton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency (ACUTE FAILURE)</u> <u>420.1</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Also terminal aspiration of stomach contents.....</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-4-minutes</u> <u>***---</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>OCTOBER 10, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thayerville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spald N. Minnich</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Friend</u>	

DATE SIGNED



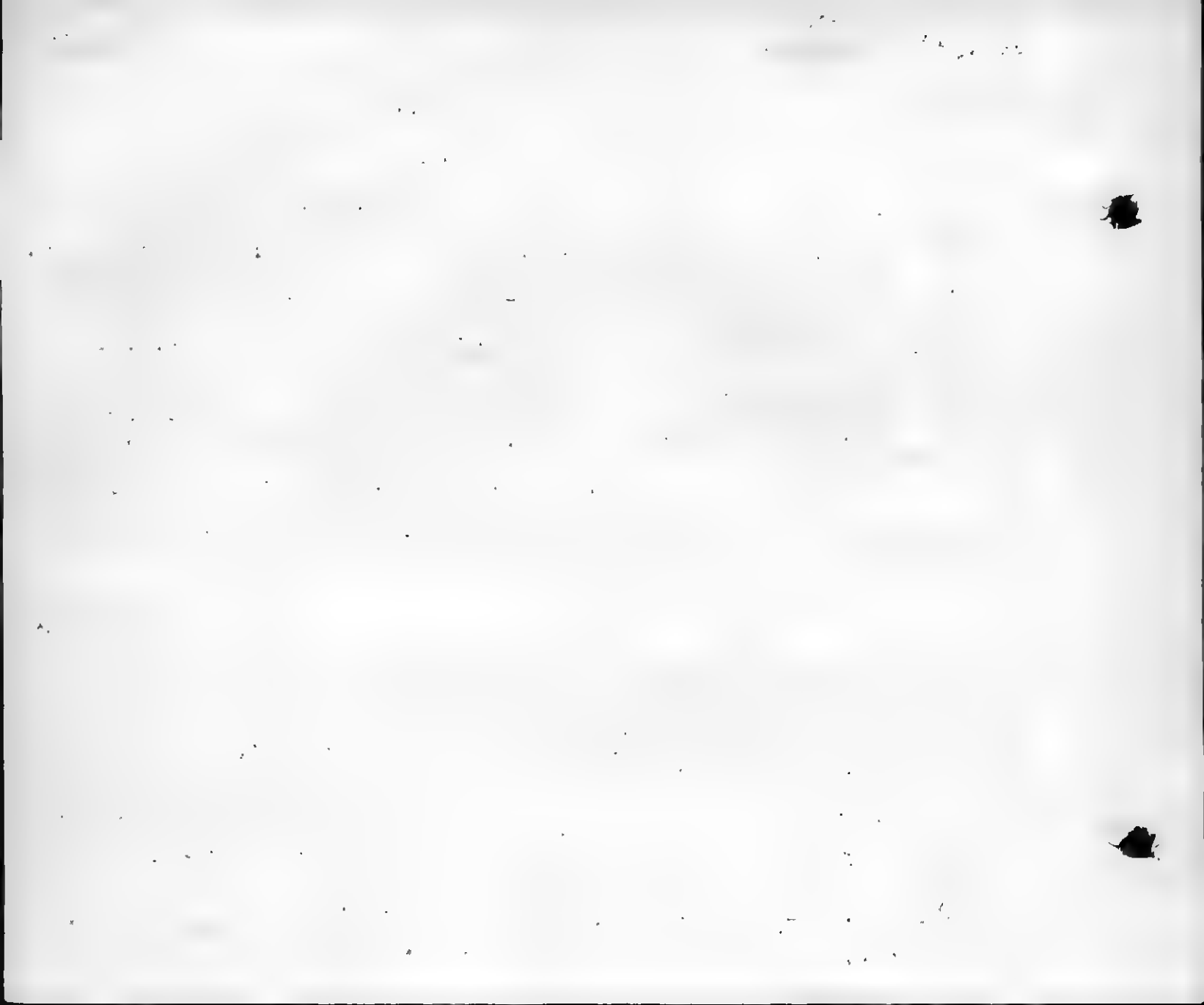
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

X

(I)

MARYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
10934 CERTIFICATE OF DEATH 10904											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg						c. LENGTH OF STAY IN 1b 10 years					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 Hill Street						e. STREET ADDRESS 126 Hill Street					
3. NAME OF DECEASED (Type or print) First SARAH Middle ALICE Last KREITZBURG						4. DATE OF DEATH Month 10 Day 1 Year 19 60.					
5 SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4-9-1877		9 AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Eckhart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Townsen Porter						14. MOTHER'S MAIDEN NAME Mary Ann Rephann					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None						16 SOCIAL SECURITY NO. None		INFORMANT Mrs. Albert Miller, 126 Hill St.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion										INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Hypertensive cardiovascular disease										years	
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from July , 19 50 , to Oct-1 , 19 60 that I last saw the deceased alive on October 1, 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE John B. Davis , M.D.						ADDRESS (Street, city or town, state) 2 BROADWAY			DATE SIGNED 10/4/60		
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-4-60		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery				22d. LOCATION (City, town, or county) (State) Eckhart Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bulah H. Montezano						24. REC'D BY REGISTRAR DATE OCT 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 235 Independence Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jessie Middle May Last Langford		4. DATE OF DEATH Month October Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1902
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Roby		14. MOTHER'S MAIDEN NAME Marie Layton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT C. C. Roby		Address 403 Linden St., Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 1-2 Hrs. -----
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED OCTOBER 7, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/60	22c. NAME OF CEMETERY OR CREMATORY Reckley Cemetery	22d. LOCATION (City, town, or county) (State) Pickard Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR OCT 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10905

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10906

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CULBERLAND</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORNELIUS</u> Middle <u>W</u> Last <u>LEONARD</u>		4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1960</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/17/17</u>
9. AGE (In years lost birthday) <u>43</u> yrs.		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>PA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE LEONARD</u>	
14. MOTHER'S MAIDEN NAME <u>ANNIE RINGER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>175-16-8942</u>		17. INFORMANT <u>CHART</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>10 - 21</u> <u>1960</u> to <u>10 - 27</u> <u>1960</u> , that (I) (we) lost the deceased alive on <u>10 - 27</u> <u>1960</u> , and that death occurred at <u>2</u> p.m., from the causes and on the date stated above.			
22a. SIGNATURE <u>R. W. Ballin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR. R. W. BALLIN</u>		22d. ADDRESS <u>62 GREENE STREET</u> <u>10-28-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Silbaugh Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>R.D. Confluence, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Humbert</u>		25a. REC'D BY REGISTRAR <u>OCT 31 '60</u>	
ADDRESS <u>Confluence, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Thomas</u>	

4-10-1951



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

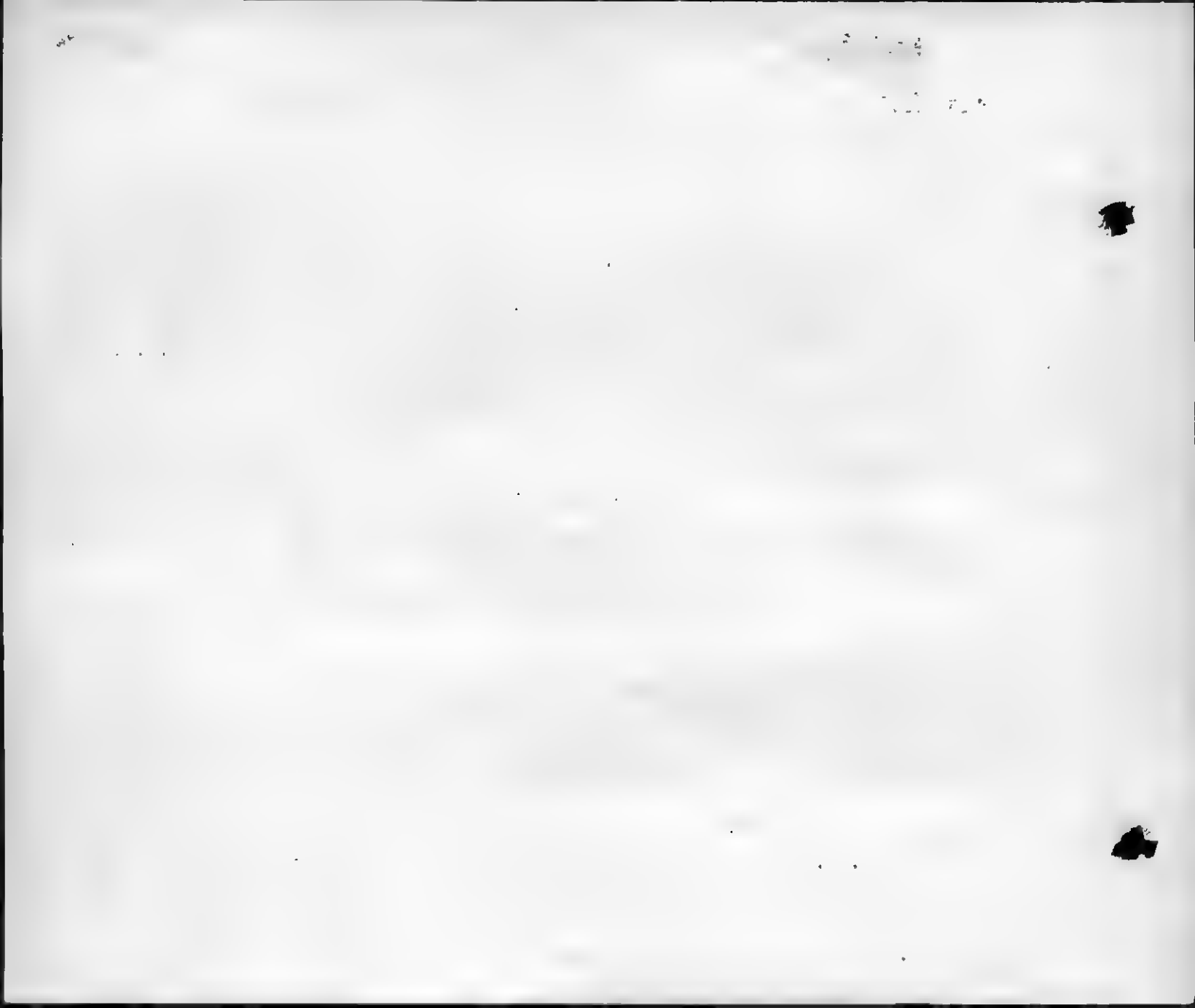
VR A15 (4)
15M 9/59

10906

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10907

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUTH A. LIVENGOOD				4. DATE OF DEATH Month Day Year OCTOBER 27, 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-1900	
9. AGE (In years last birthday) 60 yes.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME MATTHEW JONES				14. MOTHER'S MAIDEN NAME Mary Hetrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT CHART Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism DUE TO 584X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) suppurative disease of gallbladder DUE TO (c) cholelithiasis INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10-15, 1960 to 10-27, 1960 , that (I) (we) last saw the deceased alive on 10-27, 1960 , and that death occurred at 4:10 P.M. from the causes and on the date stated above							
22a. SIGNATURE L. Brings				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. L. BRINGS	
22d. ADDRESS 57 Bruce D Cumberland Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/29/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City, town, or county) Cumberland				23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 31 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

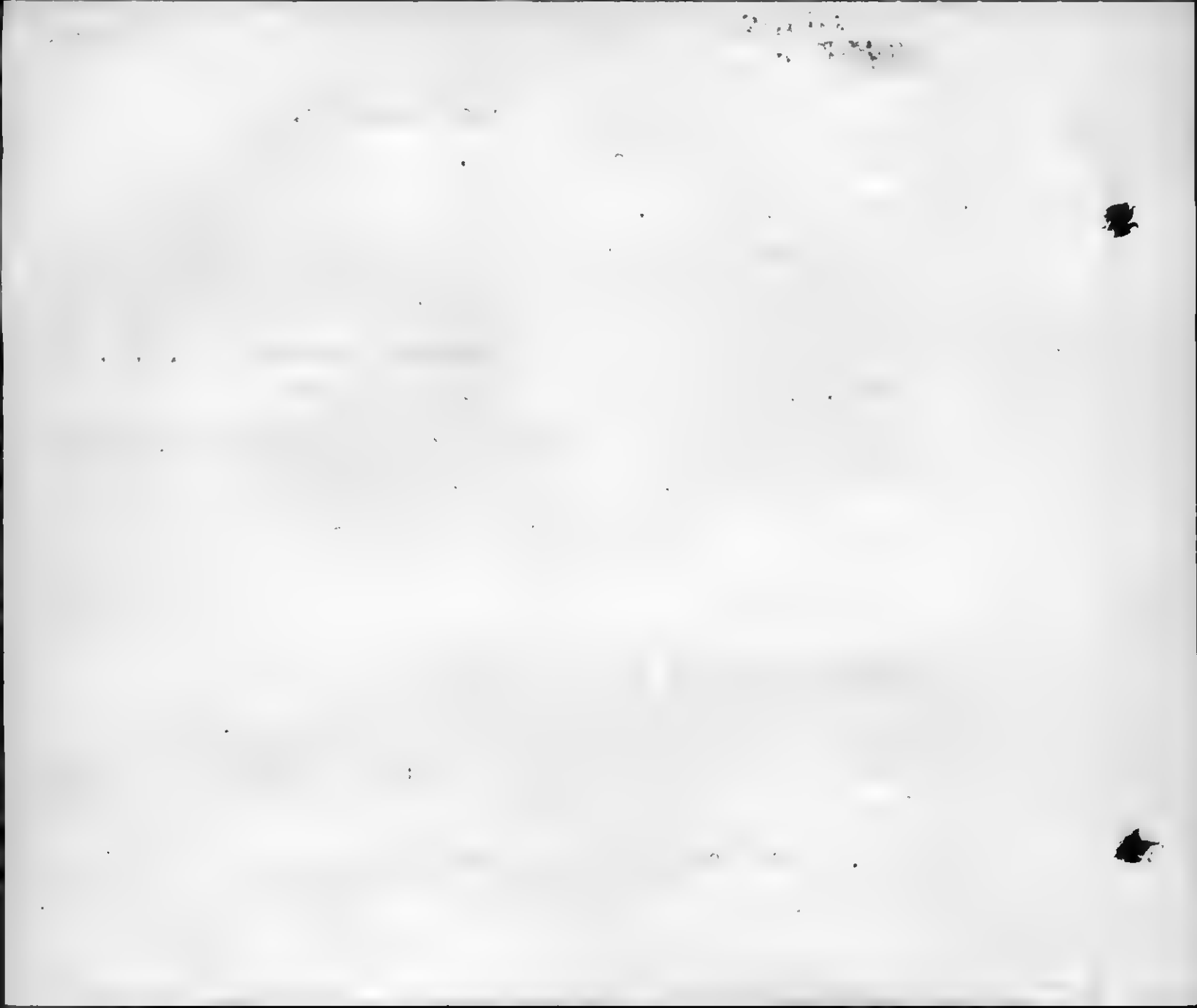


1
10907

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10908

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA PA. b. COUNTY HYNDMAN c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN d. STREET ADDRESS 1002 HALLAND ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle BOY (A) Last MAY				4. DATE OF DEATH Month OCTOBER Day 5 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 3, 1960	
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1		11. IF UNDER 24 HRS. Days 20		12. Hours 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME ROSS A. MAY				14. MOTHER'S MAIDEN NAME BETTY JEAN FRANKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cardiac Insufficiency due To Endocardial Fibro-Elastosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 2 days DUE TO (b) 2 days DUE TO (c) 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 Oct 1960 to 5 Oct 1960 , that (I) (we) last saw the deceased alive on 5 Oct 1960 , and that death occurred at 7:20 PM from the causes and on the date stated above							
22a. SIGNATURE Leland Ransom				22b. DATE 5 Oct 1960		22c. PHYSICIAN'S NAME (Type) DR. LELAND RANSOM	
22d. ADDRESS 1002 Halland St., 63 Greene St.				22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Oct. 6, 1960		Hyndman Cemetery		Hyndman, Pa. Bedford Co.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler				ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE OCT 10 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Farris	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

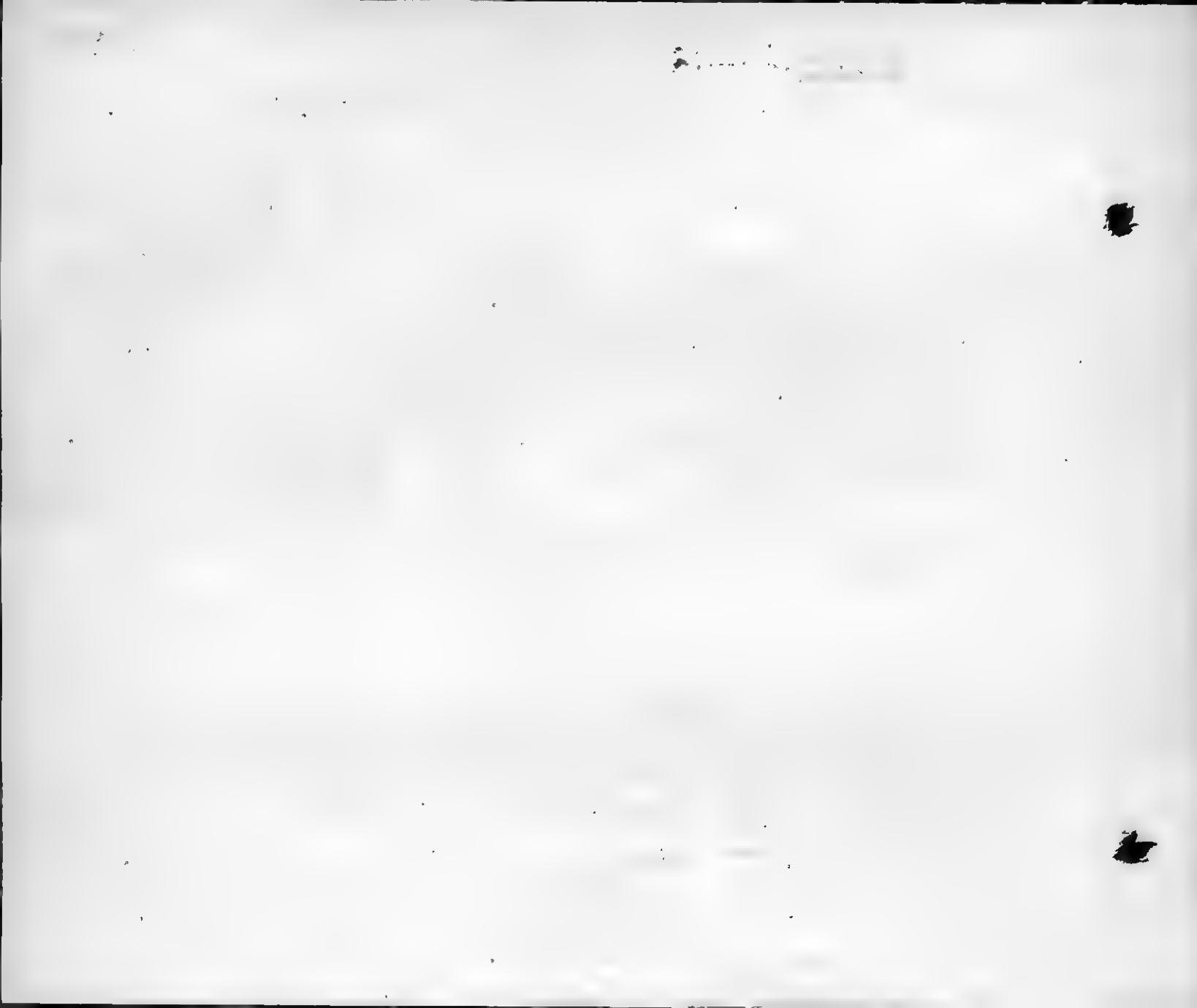
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10935

10909

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle J. Last McGUIRE		4. DATE OF DEATH Month OCTOBER Day 2 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 29, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK McGUIRE		14. MOTHER'S MAIDEN NAME CATHERINE DRISCOLL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MRS. PATRICK McGUIRE, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420-0 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1960 to Oct 2, 1960 that (I) (we) last saw the deceased alive on Oct 2, 1960 and that death occurred at 130 from the causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 10/3/60	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-5-60	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Bunt		25a. REC'D BY REGISTRAR DATE OCT 4 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

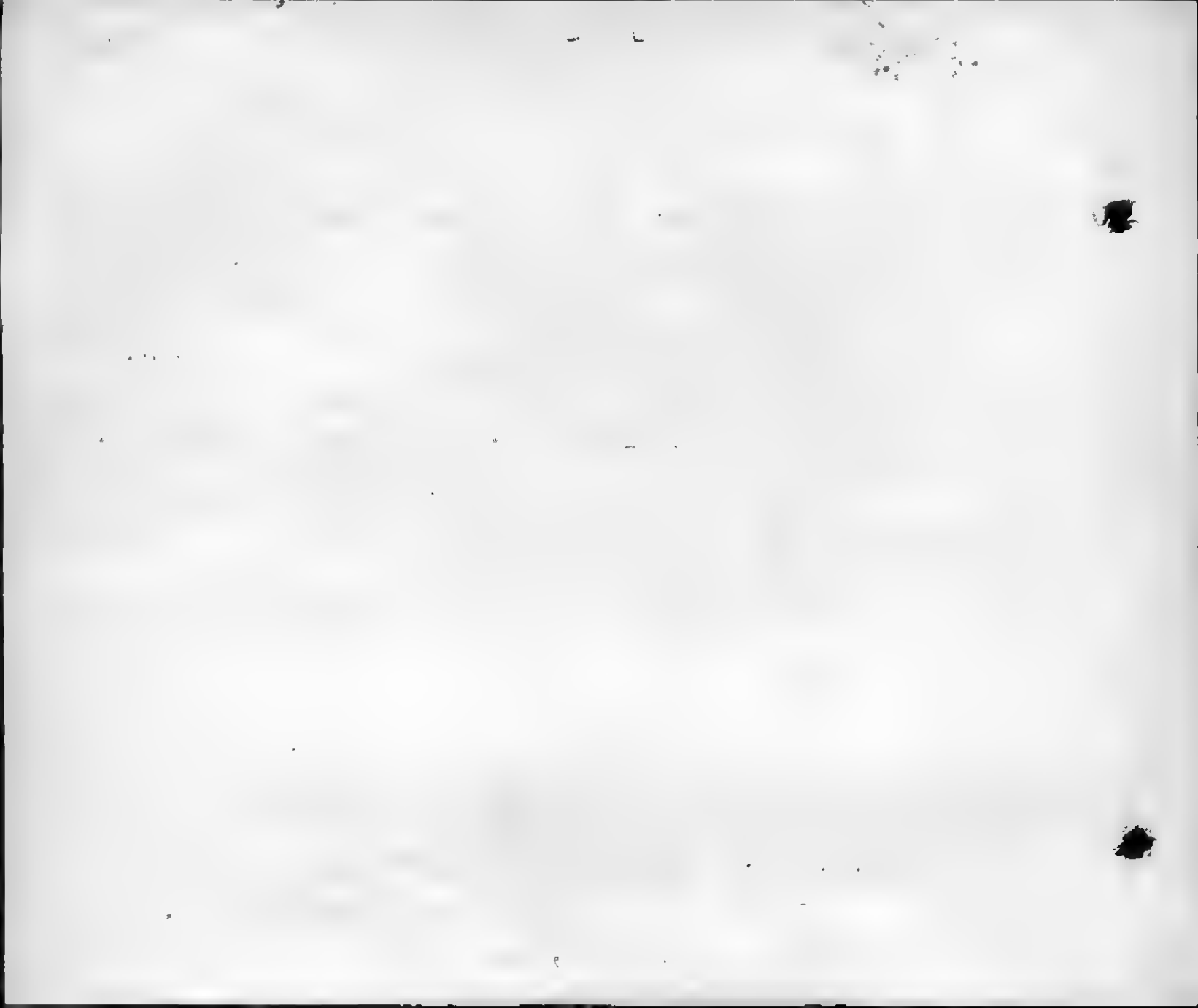
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in, and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10908

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10910

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. STREET ADDRESS RAILROAD STREET			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle N Last MONAHAN				4. DATE OF DEATH Month Oct. Day 6 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/01	9. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK MONAHAN				14. MOTHER'S MAIDEN NAME CATHERINE MULLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-05-9675		17. INFORMANT Address Mrs. Agnes Monahan, Midland, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 54X DUE TO concomitant of the infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 12 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-4- 19 59 to 10-6- 19 60 , that (I) (we) last saw the deceased alive on 10-6- 19 60 , and that death occurred at M , from the causes and on the date stated above							
22a. SIGNATURE L. Brings				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS	
22d. ADDRESS 57 GREENE STREET				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1960		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				24b. ADDRESS LONACONING? MD.		25a. REC'D BY REGISTRAR OCT 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Krasa			



10947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10911

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Rural)			c. LENGTH OF STAY IN 1b years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3 Valley Road			d. STREET ADDRESS Route 3, Valley Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDNA First PEARL Middle MOORE Last			4. DATE OF DEATH October 17 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1897	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carlos, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Griffith Anderson			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO None		17. INFORMANT Rt. 3. Valley Road Emory M. Moore, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis with Thromboembolism 4-22-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 10-10-1960 to 10-17-1960 that (I) (we) last saw the deceased alive on 10-10-1960 and that death occurred at 7:28 PM , from the causes and on the date stated above					
22a. SIGNATURE James T. Johnson, Jr. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> Oct. 18, 1960 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) James T. Johnson, Jr. 22d. ADDRESS 16 Greene Street, Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/60		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park	
23d. LOCATION (City, town, or county) (State) Cumberland, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			25a. REC'D BY REGISTRAR DATE OCT 21 '60		
			25b. REGISTRAR'S SIGNATURE Charles E. Howard		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

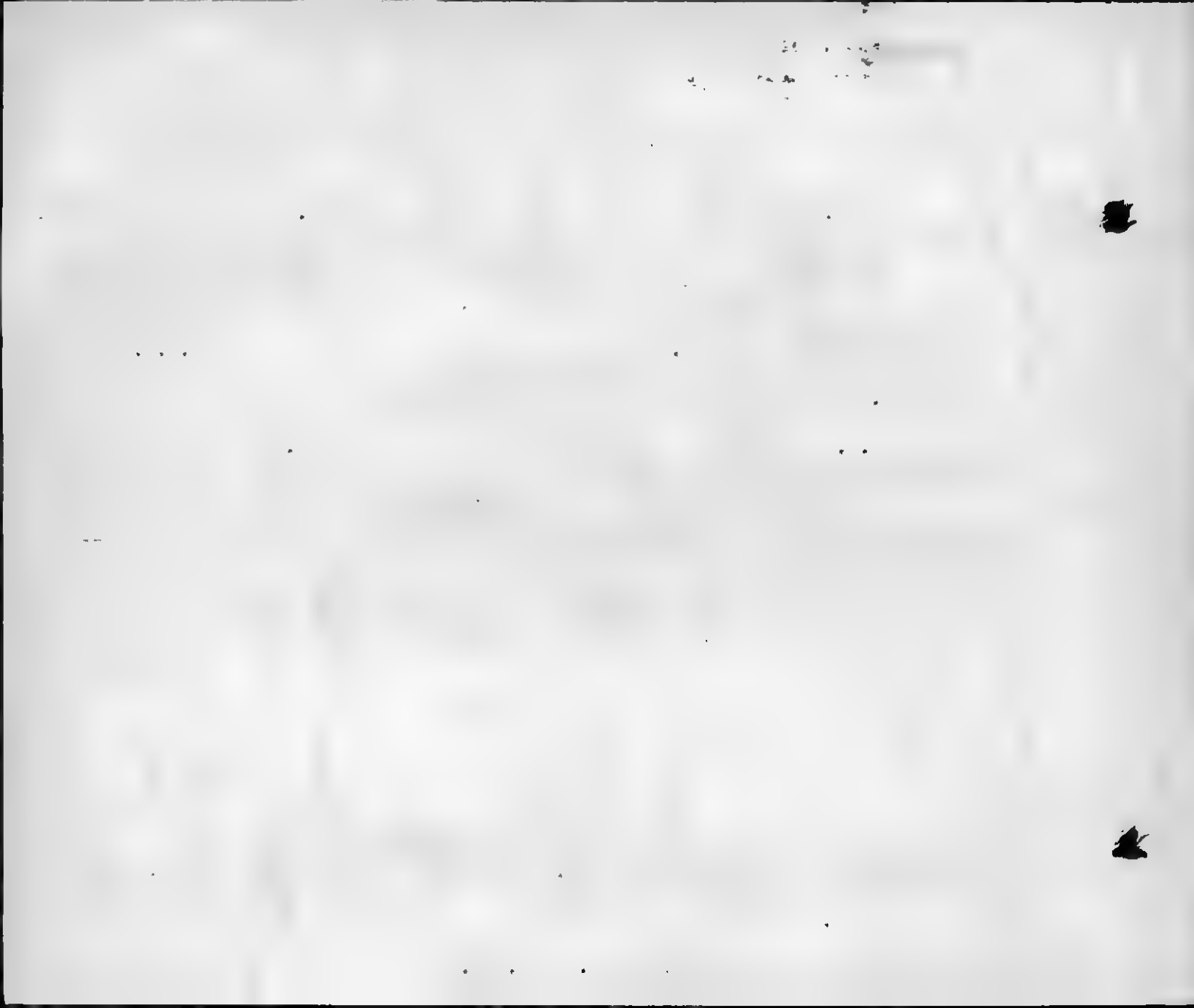
10909

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumbe rland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 410 Fayette St.				d. STREET ADDRESS 410 Fayette St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Somerville Middle Nicholson Last				4. DATE OF DEATH Month October Day 31 Year 1960			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assessment Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Allegany County		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus S. Nicholson				14. MOTHER'S MAIDEN NAME Linny Bell Wilking			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Address Somerville Nicholson Jr. Alexandria, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION, LEFT DUE TO Conditions, if any, which gave rise to immediate cause (b) SCLEROSIS WITH THROMBOSIS DUE TO (c) 4201 SCLEROSIS WITH THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH SUDDEN +++---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Hypertrophy, marked							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		OCTOBER 31, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 117 Frederick St. Cumb. Md.				24a. REC'D BY REGISTRAR NOV 2 '60		24b. REGISTRAR'S SIGNATURE Clifton S. Thomas	



CERTIFICATE OF DEATH

10913

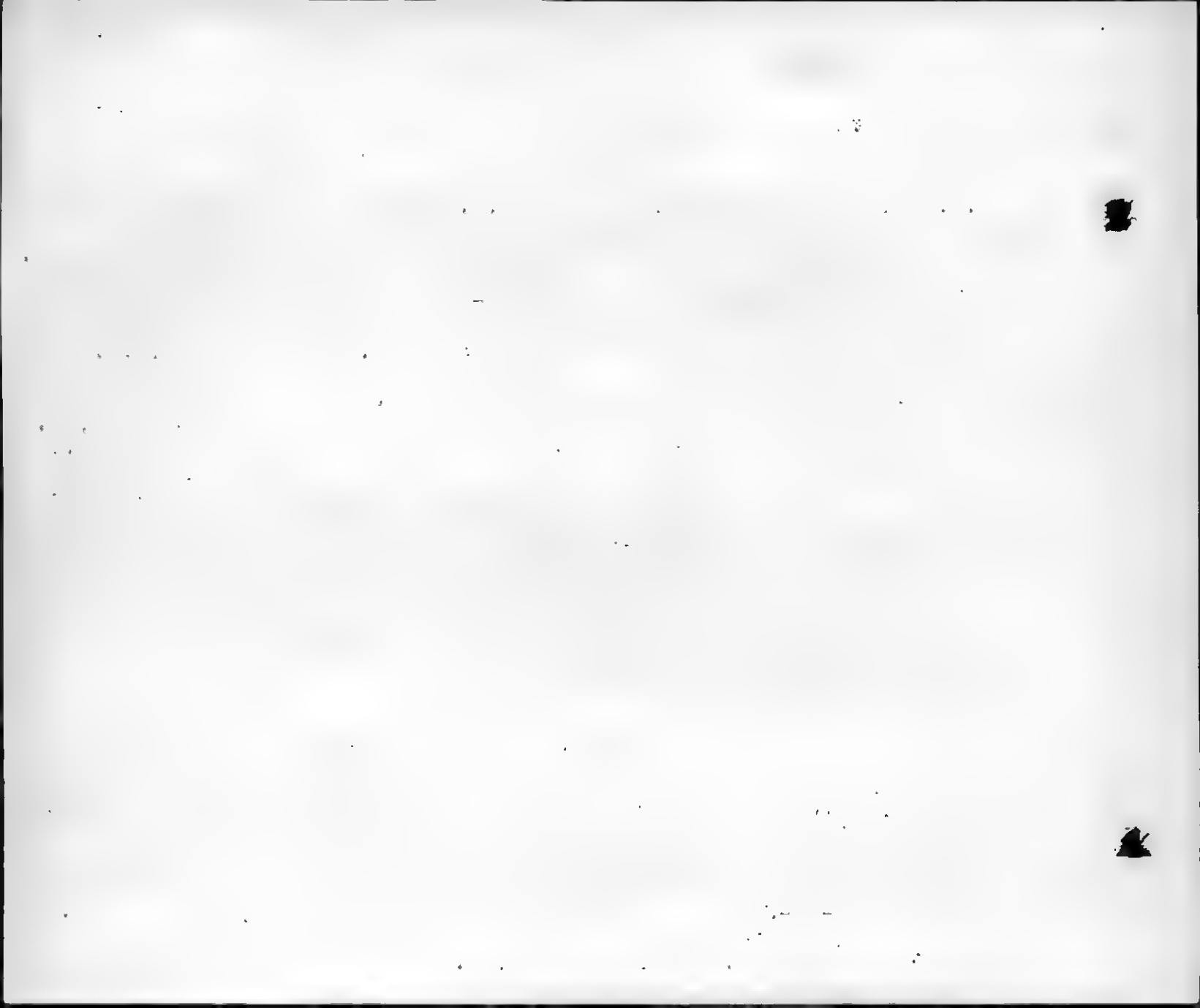
Reg. Dist. No.

10948

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN TB Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1, Box 38, (New Shaft)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUSBEE Middle S. Last PLUMMER		4. DATE OF DEATH Month 10 Day 9 Year 19 60.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Shaft, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David H. Plummer		14. MOTHER'S MAIDEN NAME Carolina Seaton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO 220-10-0776	
17. ADDRESS Frostburg, Md.		18. ADDRESS 162 East College Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H C U D (c) 24 hrs Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 53 , to Sept , 19 60 , that I last saw the deceased alive on Sept , 19 60 , and that death occurred at 11:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 B. ROADWAY DATE SIGNED 10/11/60 ACTUAL SIGNATURE John B. Davis, M.D. PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-60	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montecino		24a. REC'D BY REGISTRAR Hafer Funeral Home DATE OCT 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

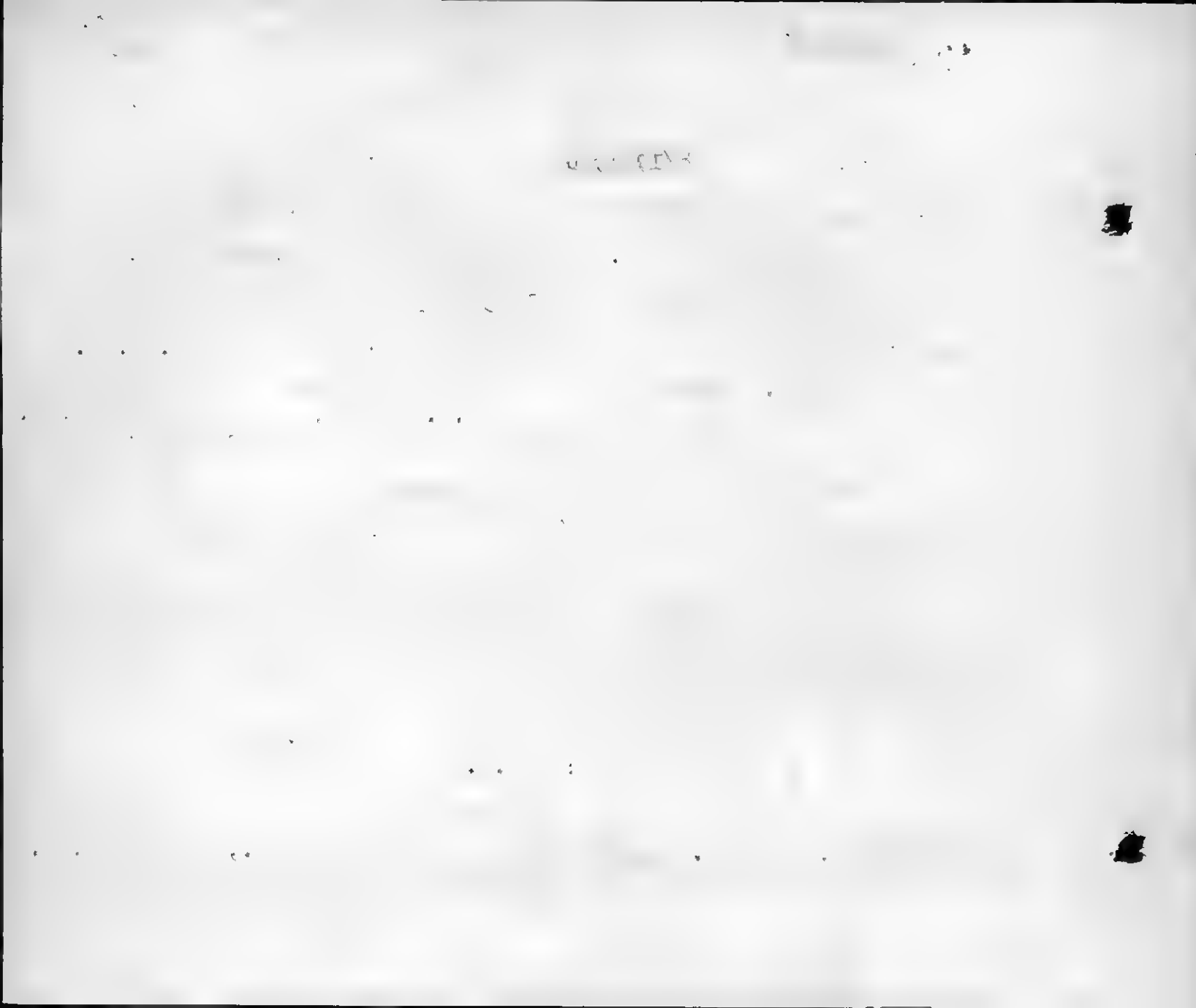
VR A15 (4)
15M 9/59

10910

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10914

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/19/1960	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Cumberland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary	
d. STREET ADDRESS 202 Grand Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle D. Last Poland		4. DATE OF DEATH Month October Day 21 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel M. Cooper		14. MOTHER'S MAIDEN NAME Mary Carlile	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO 26 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Degeneration DUE TO ? (c) Diabetes mellitus DUE TO ?		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/19/60 , 19____, to 10/21/60 , 19____, that (I) (we) last saw the deceased alive on 10/20/60 , 19____, and that death occurred at 1:10 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean M.D.		22b. DATE SIGNED 10/21/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMAT ON, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-23-60	
23c. NAME OF CEMETERY OR CREMATORY Babtist Cem.		23d. LOCATION (City, town, or county) (State) Three Churches, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Krand			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

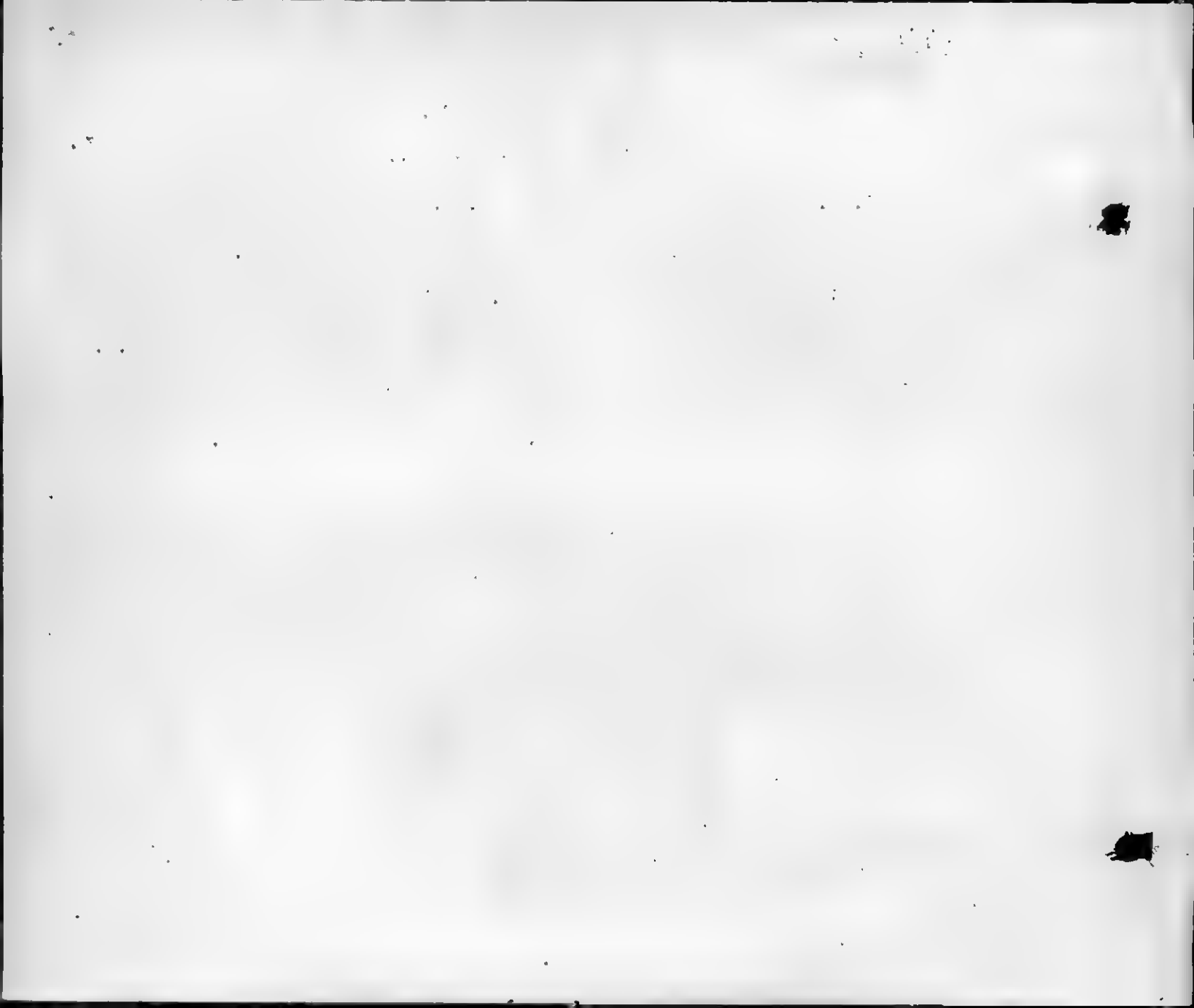
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10949

10915

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural				c. LENGTH OF STAY IN 1b 86 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Mi. E. Barton				d. STREET ADDRESS 1 Mi. E. Barton			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF Any First Ellen Middle Preston Last				4. DATE OF DEATH Month Oct. Day 29 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 4, 1874	
9. AGE (In years lost birthday) 86 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Metz				14. MOTHER'S MAIDEN NAME Ellen Poland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Charles Ross-Rawlins, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY. 422.1 IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 3 Hours 5 Years 5 Years</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb 10, 1960 to Oct. 29, 1960 , that (I) (we) last saw the deceased alive on Oct. 29, 1960 , and that death occurred at 5:15 M, from the causes and on the date stated above.							
22a. SIGNATURE Paul R. Wilson M.D.				22b. DATE SIGNED Oct. 29, 1960			
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.				22d. ADDRESS Piedmont, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town, or county) (State) Moscow, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal				ADDRESS Western Mt., Md.		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
				25b. REGISTRAR'S SIGNATURE William S. Hume			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10916

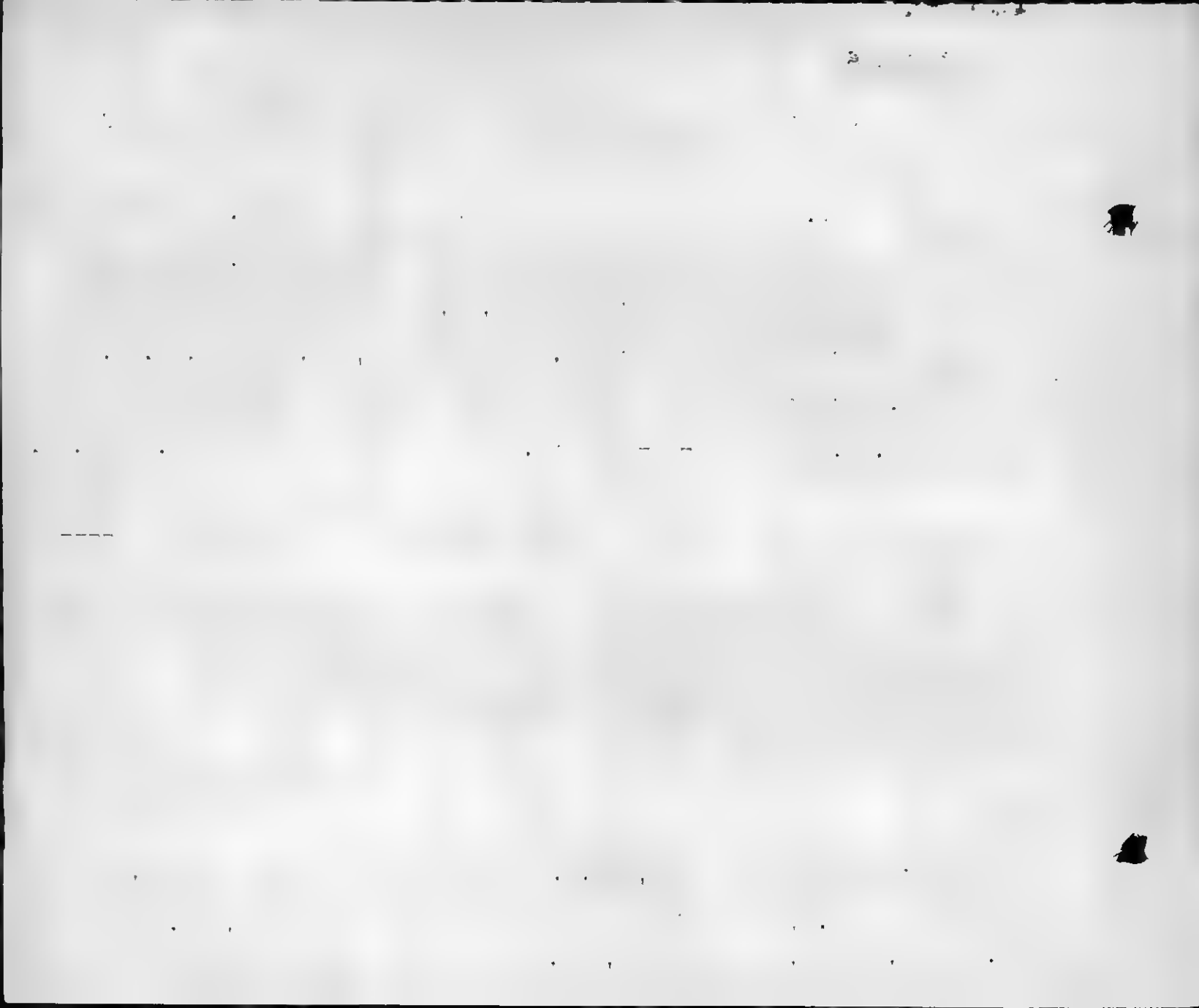
Reg. Dist. No.

10911

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>233 Beall St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u> d. STREET ADDRESS <u>552 Braddock Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>EMMETT</u> Middle <u>RESLEY</u> Last 4. DATE OF DEATH <u>Oct.</u> Month <u>2</u> Day <u>1960</u> Year			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 16, 1896</u> 9. AGE (in years last birthday) <u>64</u> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical foreman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u> 11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>John B. Resley</u> 14. MOTHER'S MAIDEN NAME <u>Isora Murray</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> If yes, give war or dates of service <u>W. W. I</u>			16. SOCIAL SECURITY NO. <u>214-07-0284</u> 17. INFORMANT <u>Mrs. Leona Zink</u> Address <u>233 Beall St. Cumb. Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o. m.</u> <u>p. m.</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>OCTOBER 2, 1960</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			
22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>		22e. (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>			
24a. REC'D BY REGISTRAR <u>OCT 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or to burial, cremation, or removal. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

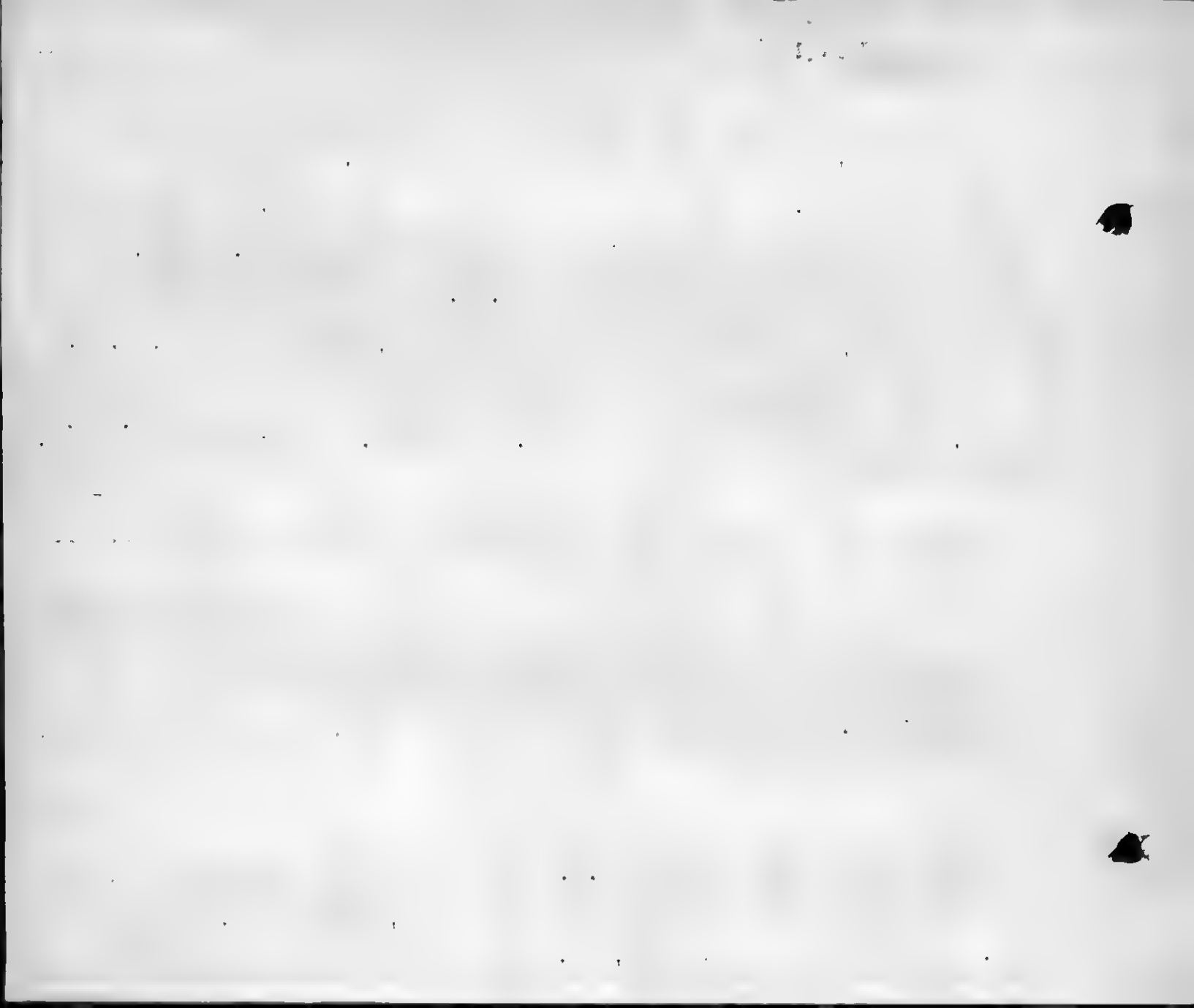
Reg. Dist. No. **10917**

10912

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		d. STREET ADDRESS Willowbrook Road,	
3. NAME OF DECEASED (Type or print) First VERDIE Middle MAY Last RICE		4. DATE OF DEATH Month Oct. Day 27, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1874
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86	IF UNDER 24 HRS. Hours 86 Min. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Twigg town, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hanson Twigg		14. MOTHER'S MAIDEN NAME Martha Hite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lillian V. Miller		Address Cumb. Md. Willowbrook Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (a), stating the underlying cause last. DUE TO (c) FRACTURE OF LEFT HIP			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF LEFT HIP			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 1		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL IN KITCHEN OF OWN HOME	
20c. TIME OF INJURY Hour 5:30 p. m. Oct. 22 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Rt. #4 Cumberland, alleg, md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED OCTOBER "27, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/29/60	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park, Cumberland, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR OCT 31 '60		24b. REGISTRAR'S SIGNATURE Christy B. Fiss	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records or to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

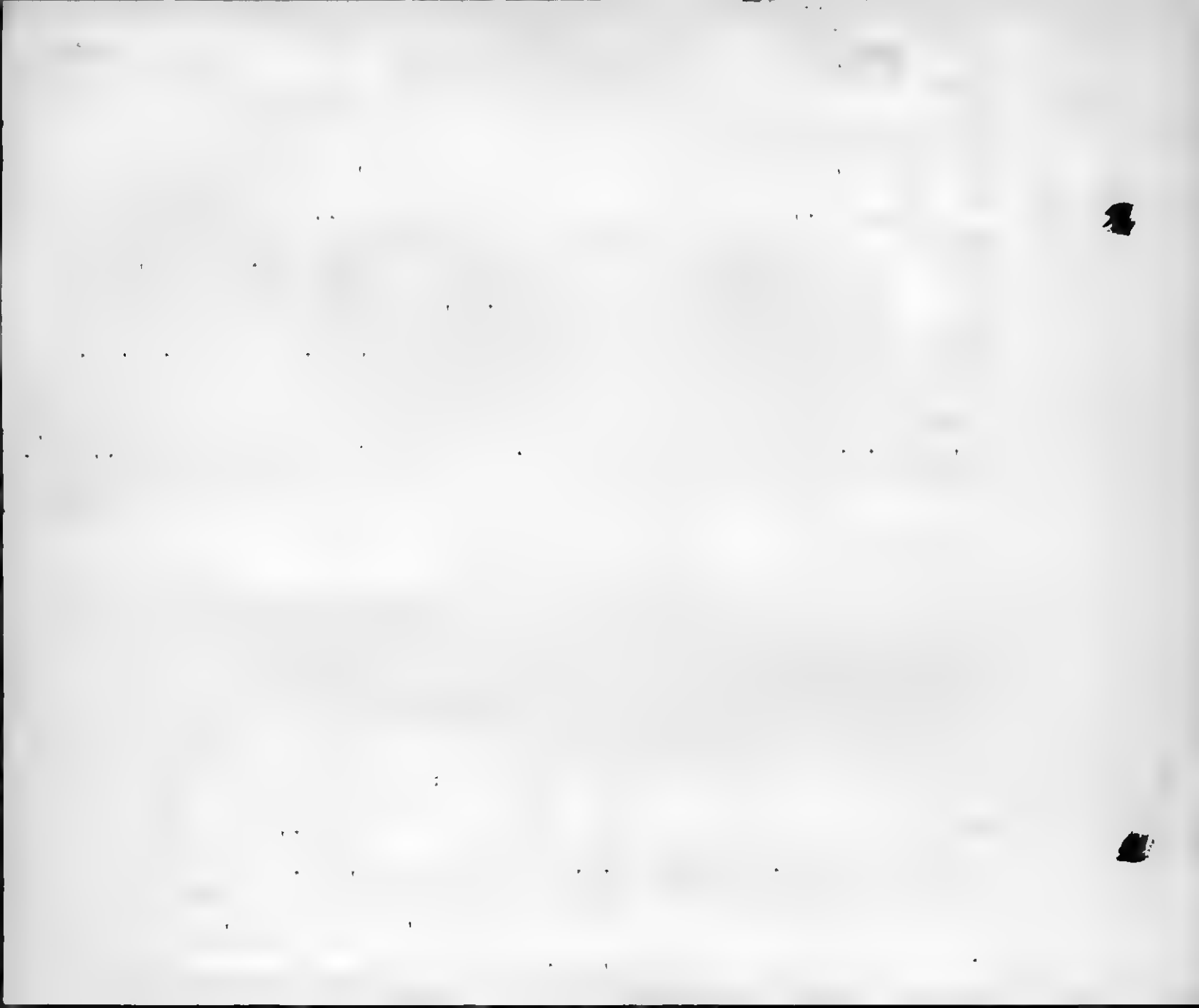
10913

CERTIFICATE OF DEATH

Reg. Dist. No.

10918

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 326 Beall St.,		d. STREET ADDRESS 326 Beall St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOHN Last ROBERTSON		4. DATE OF DEATH Month Oct. Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1898
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR: Months 6 Days 2 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Industry	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Robertson		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W.W. # 1		16. SOCIAL SECURITY NO. 216-07-2689	
17. INFORMANT Mrs. Mary Robertson		Address 326 Beall St., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) arteriosclerosis obliterans PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis obliterans INTERVAL BETWEEN ONSET AND DEATH 22 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/3/60 , 19 60 , to 11/3/60 , 19 60 , that I last saw the deceased alive on 11/3/60 , 19 60 , and that death occurred at 3:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St., DATE SIGNED 11/3/60 ACTUAL SIGNATURE Samuel M. Jacobson M.D. PHYSICIAN'S NAME (Type) Samuel M. Jacobson M.D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/60	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 4 '60		24b. REGISTRAR'S SIGNATURE William J. Hume	



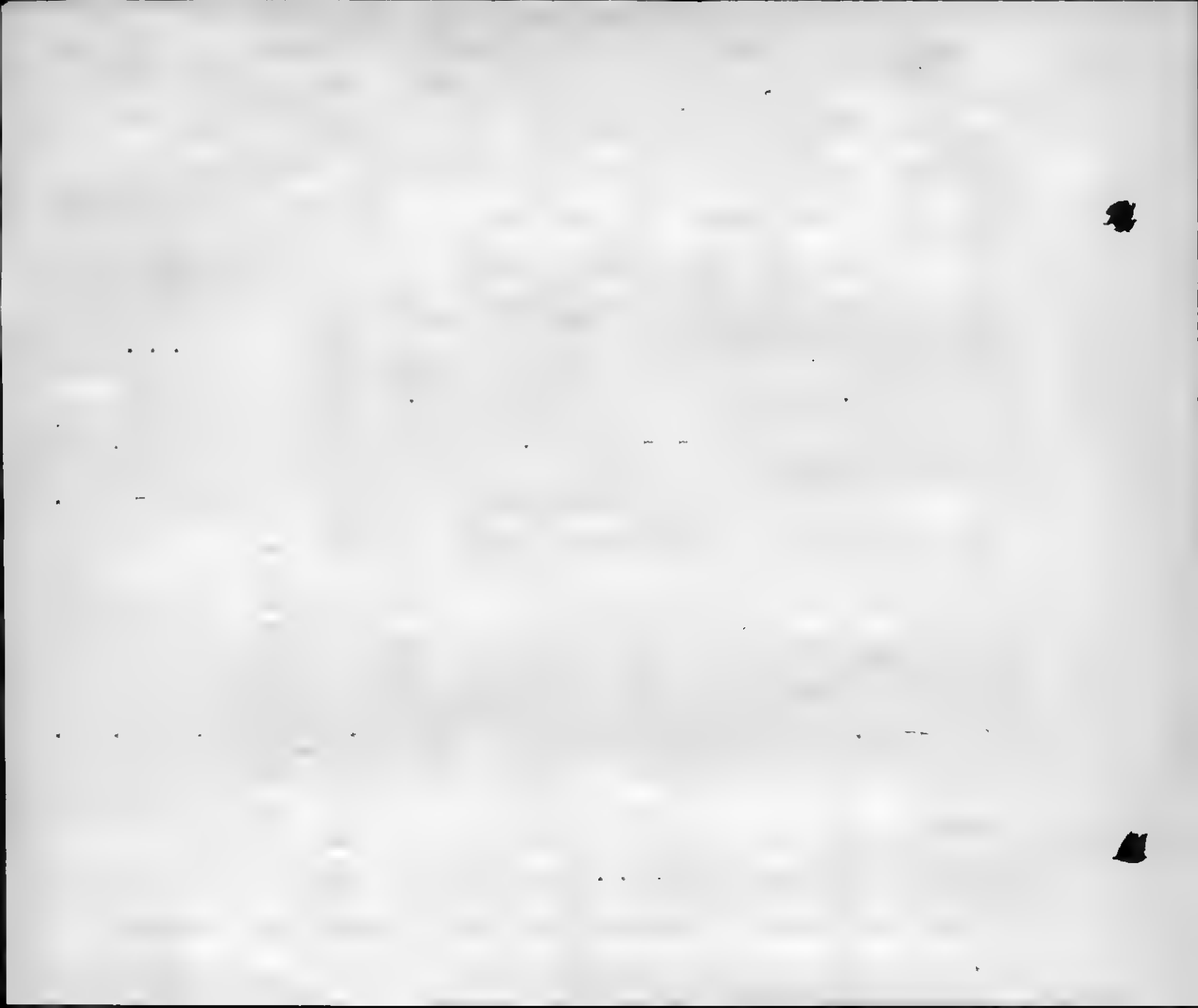
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10950

Reg. Dist. No. 10919

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt #5		c. LENGTH OF STAY IN 1b 6 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt #5			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box #311				d. STREET ADDRESS Box #311		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Stewart Last Rodeheaver				4. DATE OF DEATH Month October Day 22 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1925	
9. AGE (In years last birthday) 35 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Used car dealer		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Charles S. Rodeheaver				14. MOTHER'S MAIDEN NAME Minnie E. Teets			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-6814		17. INFORMANT Mrs. JoAnn Rodeheaver Address 468 Columbia St, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SKULL FRACTURE, CEREBRAL MACERATION, HEMORRHAGE DUE TO Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of head DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 176X						INTERVAL BETWEEN ONSET AND DEATH 5-10 Min. 11	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 1:00 a.m. Oct. 22 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rt. 5 Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarellic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED OCTOBER 22, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/60		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox Cumberland Maryland				24a. REC'D BY REGISTRAR OCT 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	



TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records or to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

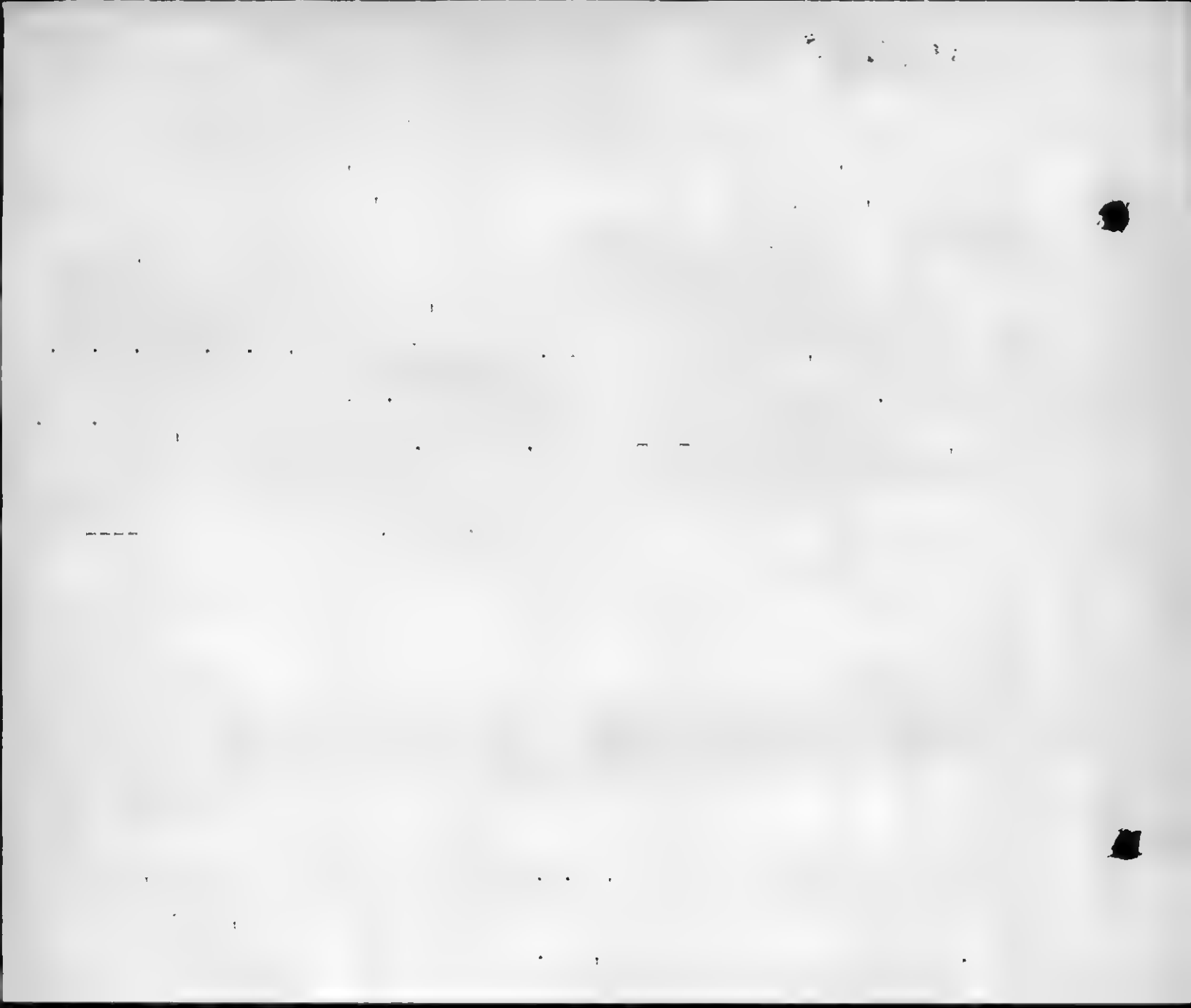
10914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10920

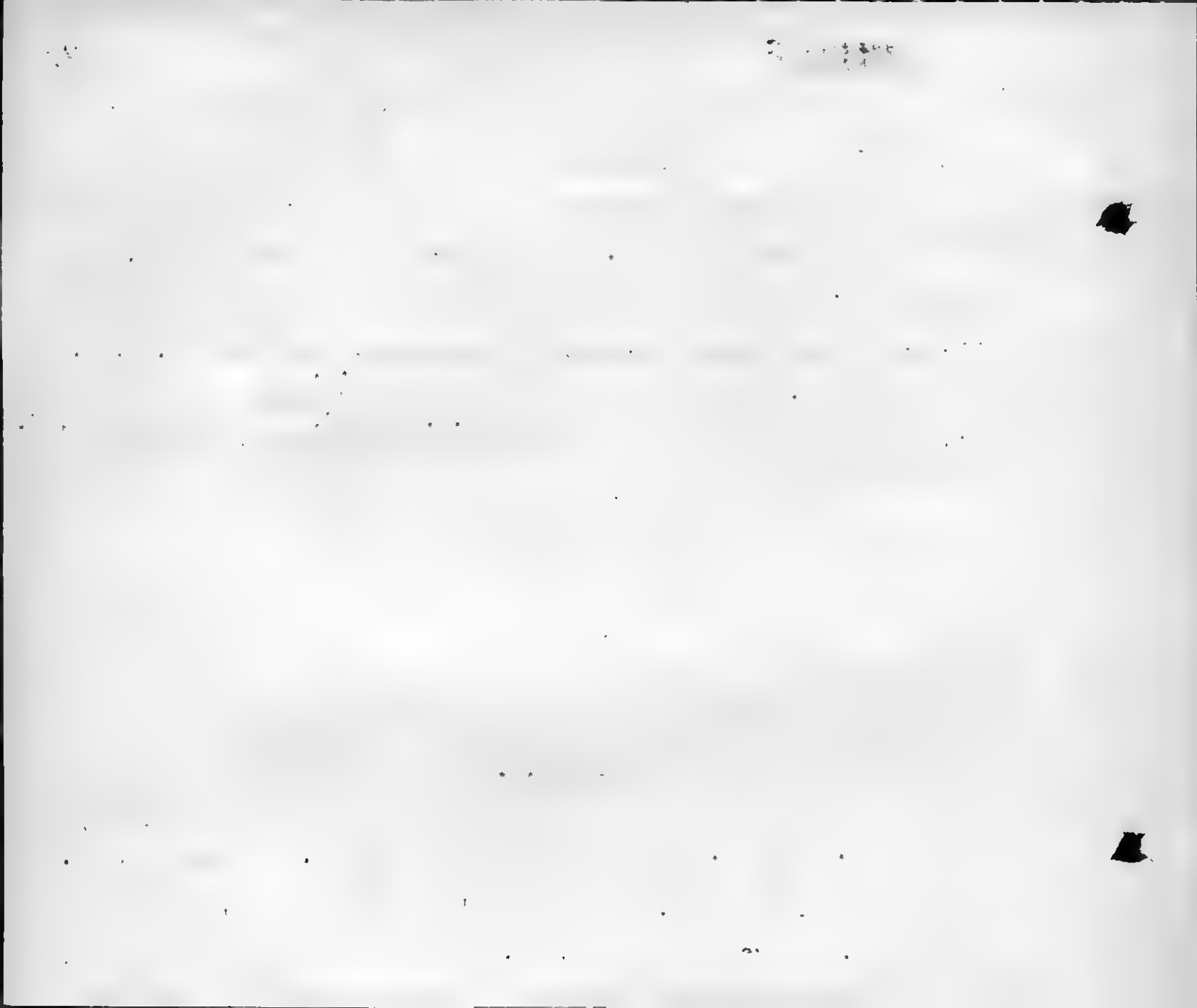
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 807 Mann's Terrace				d. STREET ADDRESS 807 Mann's Terrace			
3. NAME OF DECEASED (Type or print) First Lola Middle Belle Last Rogers				4. DATE OF DEATH Month October Day 4 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1897		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Berkley Springs, W.Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David R. Henry				14. MOTHER'S MAIDEN NAME Laura V. Cross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 216-14-1341		17. INFORMANT Mr. Carl F. Rogers		Address Cumb. Md. 807 Mann's Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		OCTOBER 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/60		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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10915
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10921

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 4/30/52		d. STREET ADDRESS 318 Beall Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle F. Last Rossworm		4. DATE OF DEATH Month October Day 26 , Year 19 60	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1890
9 AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Florist Clerk		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Vitus R. Rossworm		14. MOTHER'S MAIDEN NAME Susan Brodigan	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16 SOCIAL SECURITY NO. P.O.Box 599, Allegany County Infirmary Records	
17 INFORMANT P.O.Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertension DUE TO Chronic Hypertension Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last, (b) Bronchial Asthma DUE TO Bronchial Asthma (c) Chronic Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/30/52 19 to 10/26/60 19, that (I) (we) last saw the deceased alive on 10/25/60 19 @ 5:30 A.M. , and that death occurred at 10/26/60 M, from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 10/26/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/60	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR OCT 31 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

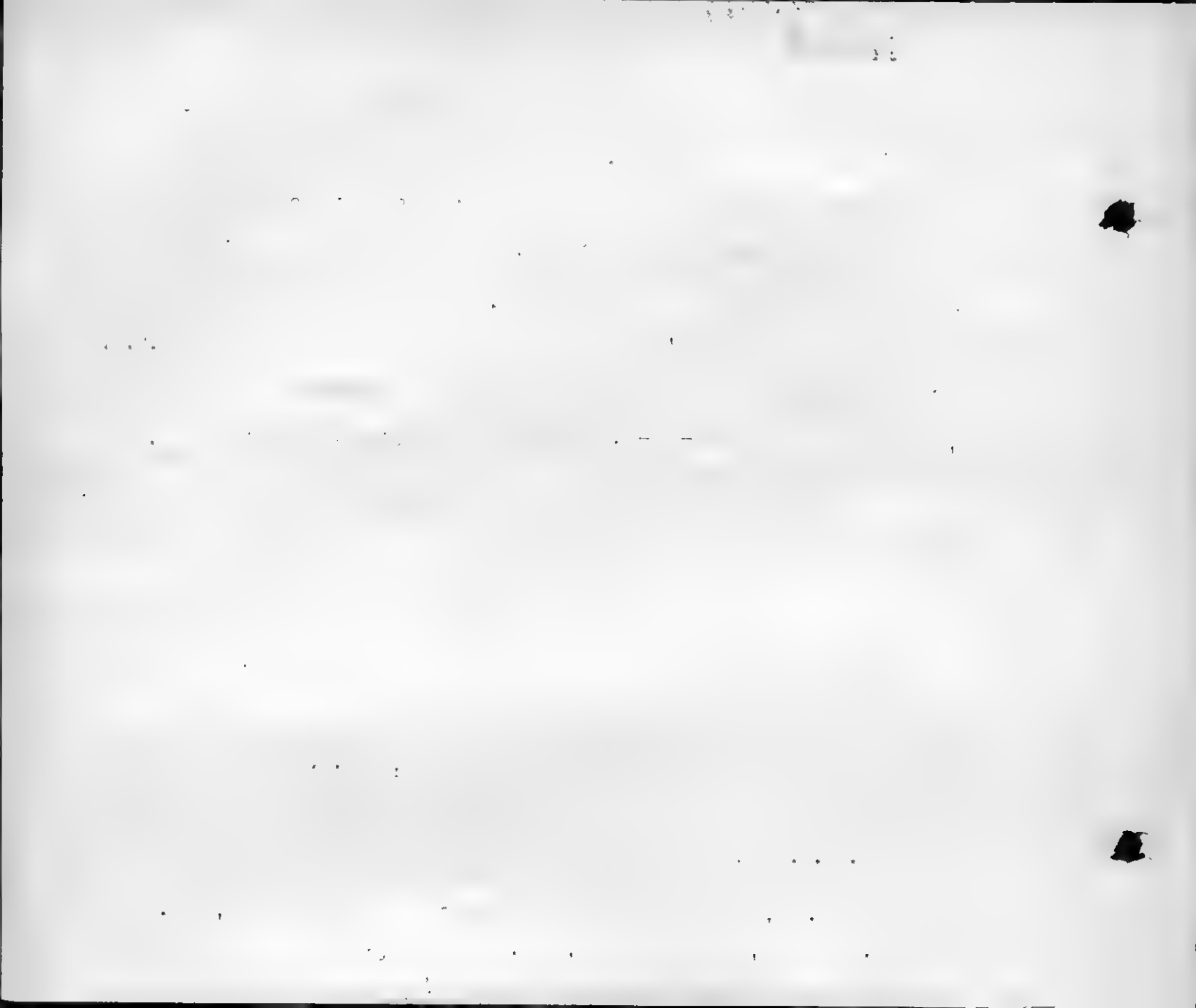


10918

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10922

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 40 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 412 WASHINGTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle SCHWARZENBACH Last				4. DATE OF DEATH Month OCTOBER Day 12 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 16, 1882		9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner in business		10b. KIND OF BUSINESS OR INDUSTRY Men's Clothing Store		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SCHWARZENBACH				14. MOTHER'S MAIDEN NAME MARGARET Wiegman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-1210		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 2-17-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-17-1960 to 10-11-1960 that (I) (we) last saw the deceased alive on 10-11-1960 and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams				22b. DATE SIGNED 10-13-60		22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS	
22d. ADDRESS Cumberland Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 14, 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kinn	



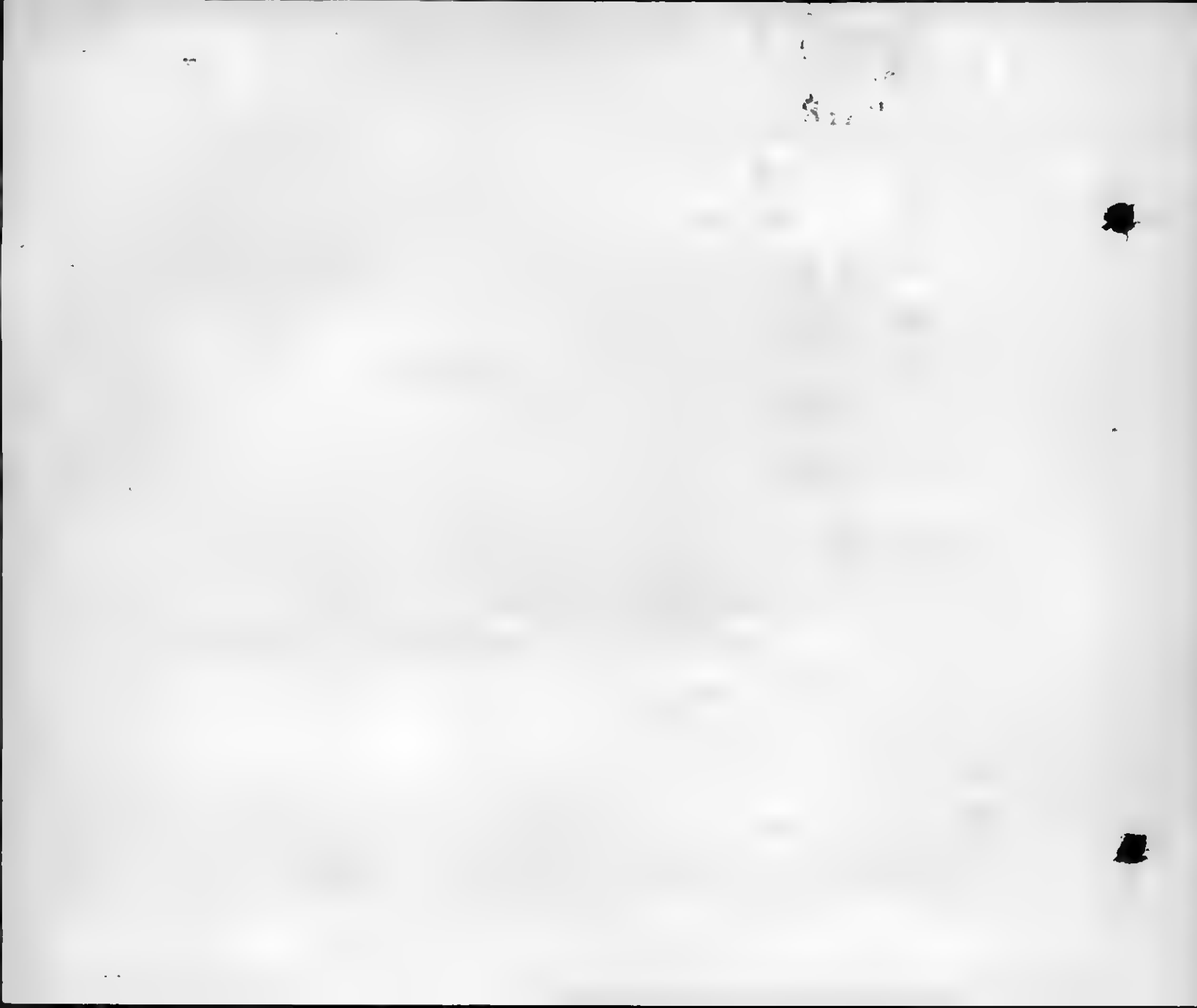
10917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 58yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. STREET ADDRESS 422 Grand Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 422 Grand Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle Schwenninger Last 4. DATE OF DEATH Oct. 31 1960				5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 4, 1883 9. AGE (In years last birthday) yrs. 76 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Hardware Store				10b. KIND OF BUSINESS OR INDUSTRY Retail Business			
11. BIRTHPLACE (State or foreign country) Luxembourg				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Nicholas Schwenninger				14. MOTHER'S MAIDEN NAME Margaret Haan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Paul Schwenninger				Address 107 South St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450. Thrombosis DUE TO Bronchial Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 5 wks 10 yrs 12 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 50 , to Oct. 31 , 19 60 , that I last saw the deceased alive on Oct. 25 , 19 60 , and that death occurred at 9:15P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland Md 21560 SIGNED							
ACTUAL SIGNATURE Clay E. Durrett M.D.							
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-60		22c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarielli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 2 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

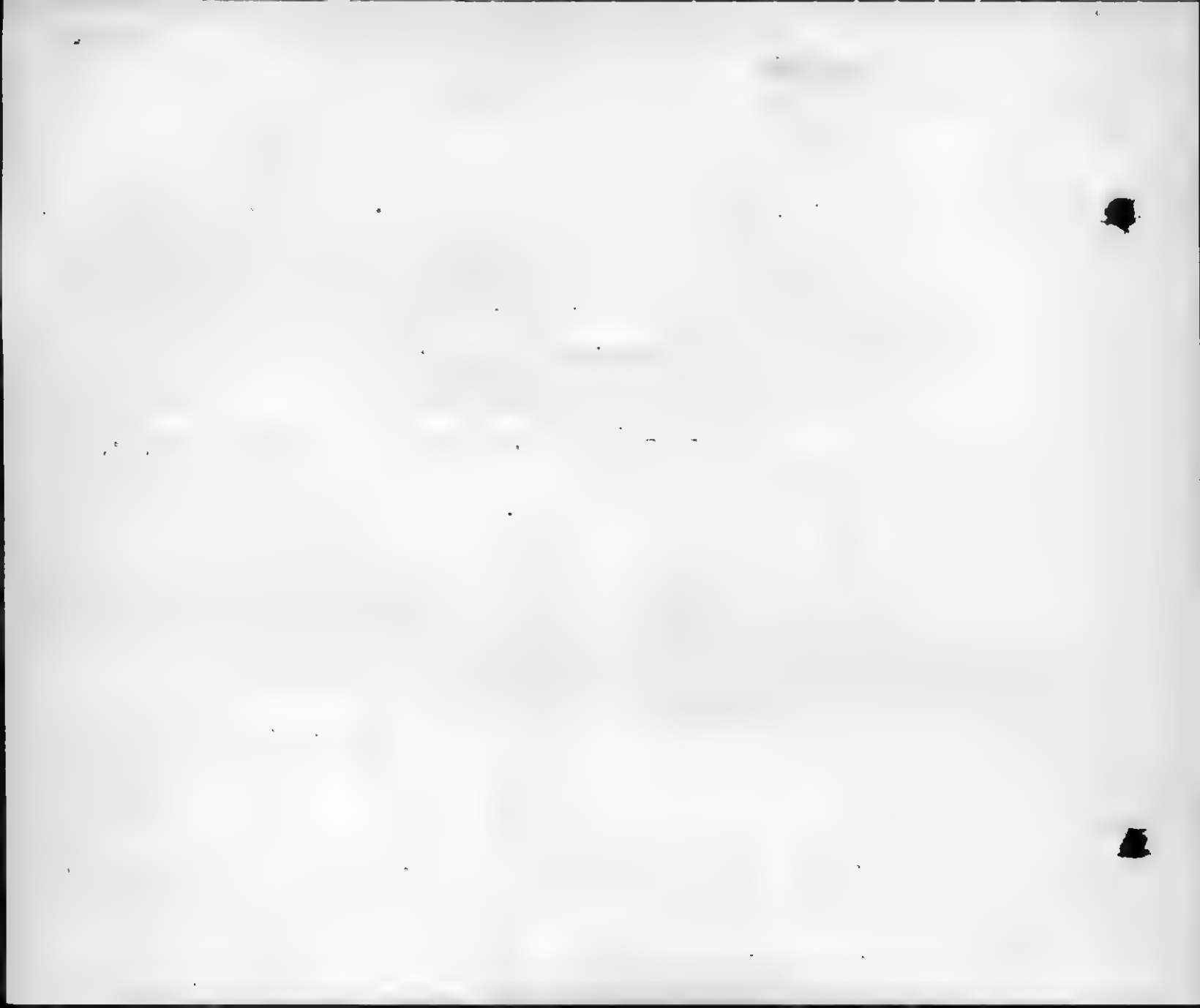
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10936

CERTIFICATE OF DEATH

10924

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 East Main Street		e. STREET ADDRESS 200 E. Main St.	
3. NAME OF DECEASED (Type or print) First Ben Middle Last Smith		4. DATE OF DEATH Month October Day 8th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 31st, 1906
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Disabled) Heater		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William H. Smith		14. MOTHER'S MAIDEN NAME Christina Walker	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 216-09-5602	
17 INFORMANT Elmer Smith, 131 Maple St., F'bg. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Several 192		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1960 to Oct 8, 1960 that (I) (we) last saw the deceased alive on Oct 7, 1960 and that death occurred at 11 AM , from the causes and on the date stated above.			
22a SIGNATURE W. O. McLane		22b DATE SIGNED Oct 9 1960	
22c. PHYSICIAN'S NAME (Type) W. O. McLane,		22d. ADDRESS 167 E. Main St., Frostburg, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10-10-60	
23c NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Burt		25a REC'D BY REGISTRAR DATE OCT 11 '60	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10938

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10925

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>All</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>01 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Rock St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Privella</u> Middle <u>Smith</u> Last		4. DATE OF DEATH <u>Oct.</u> Month <u>15</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1863</u>
9. AGE (In years lost birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jefferson Fagenbaker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. William McGee</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u> <u>10 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 12, 1960</u> to <u>Oct 15, 1960</u> , that (I) (we) lost saw the deceased alive on <u>Oct 15, 1960</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Paul R. Wilson</u> M.D.		22b. DATE SIGNED <u>Oct 17, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>		22d. ADDRESS <u>Piedmont, W. Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct. 18, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Westernport, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Est. Boal</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 20 '60</u>	
ADDRESS <u>Westernport, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

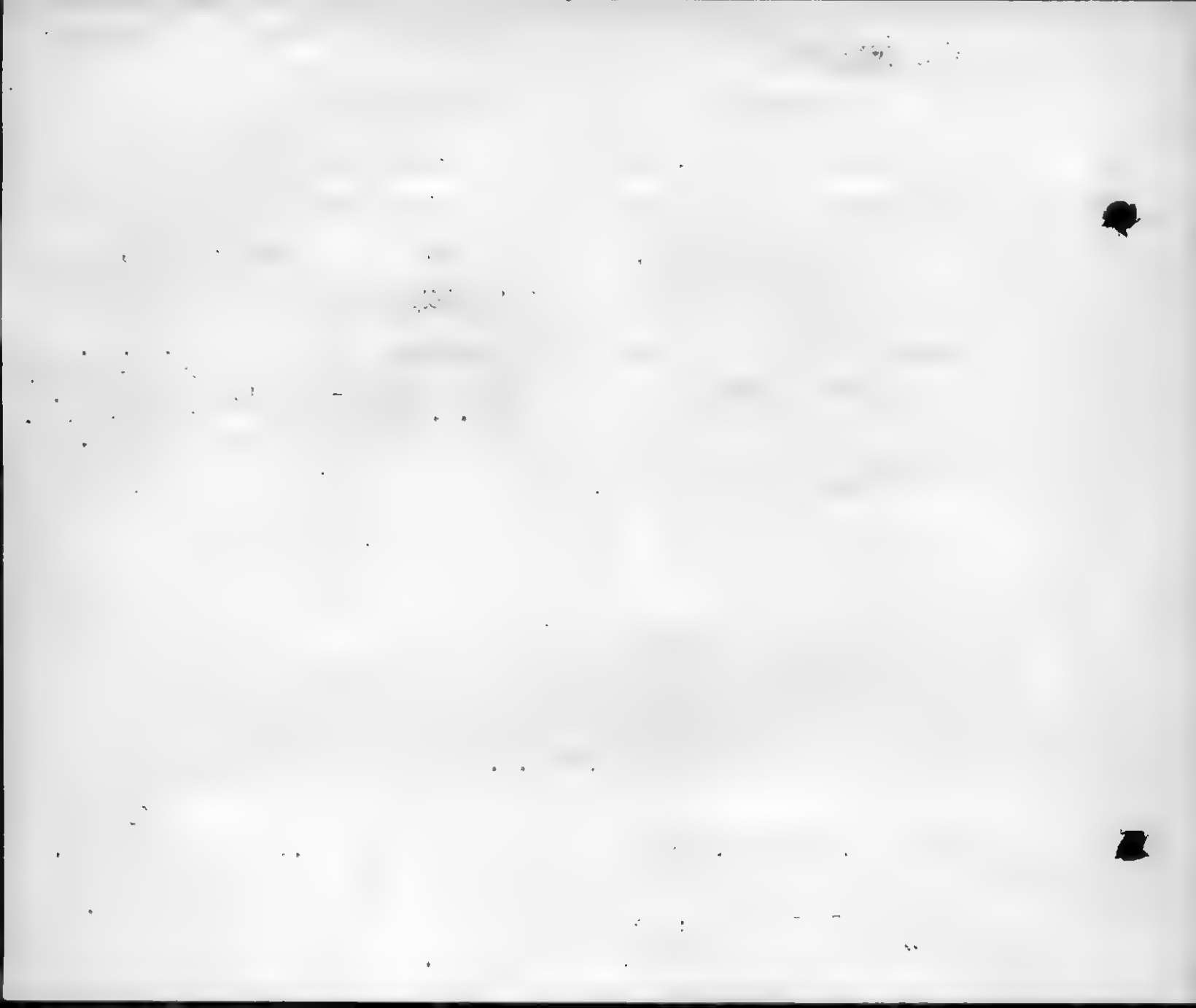
10918

10926

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/5/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS Wrights Crossing	
3. NAME OF DECEASED (Type or print) First Mary Middle R. Last Struntz		4. DATE OF DEATH Month October Day 24 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/1864
9. AGE (In years lost birthday) 96 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Tanzer		14. MOTHER'S MAIDEN NAME Born in Austria - Family Records lost - can't obtain name.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO Chronic Myocardial Degeneration DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Senile Deterioration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/5/60 , 12 to 10/24/60 , 19, that (I) (we) last saw the deceased alive on 10/24/60 , 19, and that death occurred at 5:42 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean M.D.		22b. DATE SIGNED 10/25/1960	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-27-60	
23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town, or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montross		25. REC'D BY REGISTRAR Hafer Funeral Home	
25a. ADDRESS 23 E. Main, Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files or to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>C2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Robert St. W. Md. Railroad Crossing</u>			d. STREET ADDRESS <u>119 Robert St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Leroy</u> Last <u>Swanger</u>			4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1959</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>10</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Joyce Marie Swanger</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Joyce M. Swanger</u> Address <u>119 Robert St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Struck by railroad train</u> DUE TO (c) <u>"</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>"</u>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by train</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:15</u> Hour <u>pm</u> <u>Oct. 7</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Near Robert St. Cumberland, Alleg. Md.</u>	
20f. (City or town) <u>Cumberland</u>		20g. (County) <u>Alleg.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 7, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oliver Grove Cem.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Near Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Scarpelli</u>			ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Brand</u>

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 273 10-1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10920

CERTIFICATE OF DEATH

10928

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JESSE Middle F. Last TWIGG				4. DATE OF DEATH Month OCTOBER Day 6 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-16-1884	
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		11. IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY Transfer Business			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis T. Twigg				14. MOTHER'S MAIDEN NAME Alice Kifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-32-3368			
17. INFORMANT CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral hemorrhage DUE TO (c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-6-60 to 10-7-60 that (I) (we) last saw the deceased alive on 10-6-60 and that death occurred at 11:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE D. J. Johnson Jr				22b. DATE SIGNED 10-7-60			
22c. PHYSICIAN'S NAME (Type) DR. J. T. JOHNSON Jr				22d. ADDRESS 16 Greene St, Cumberland Md			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/8/60			
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town, or county) (State) Cumberland Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				25a. REC'D BY REGISTRAR OCT 10 '60			
ADDRESS Cumberland Maryland				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

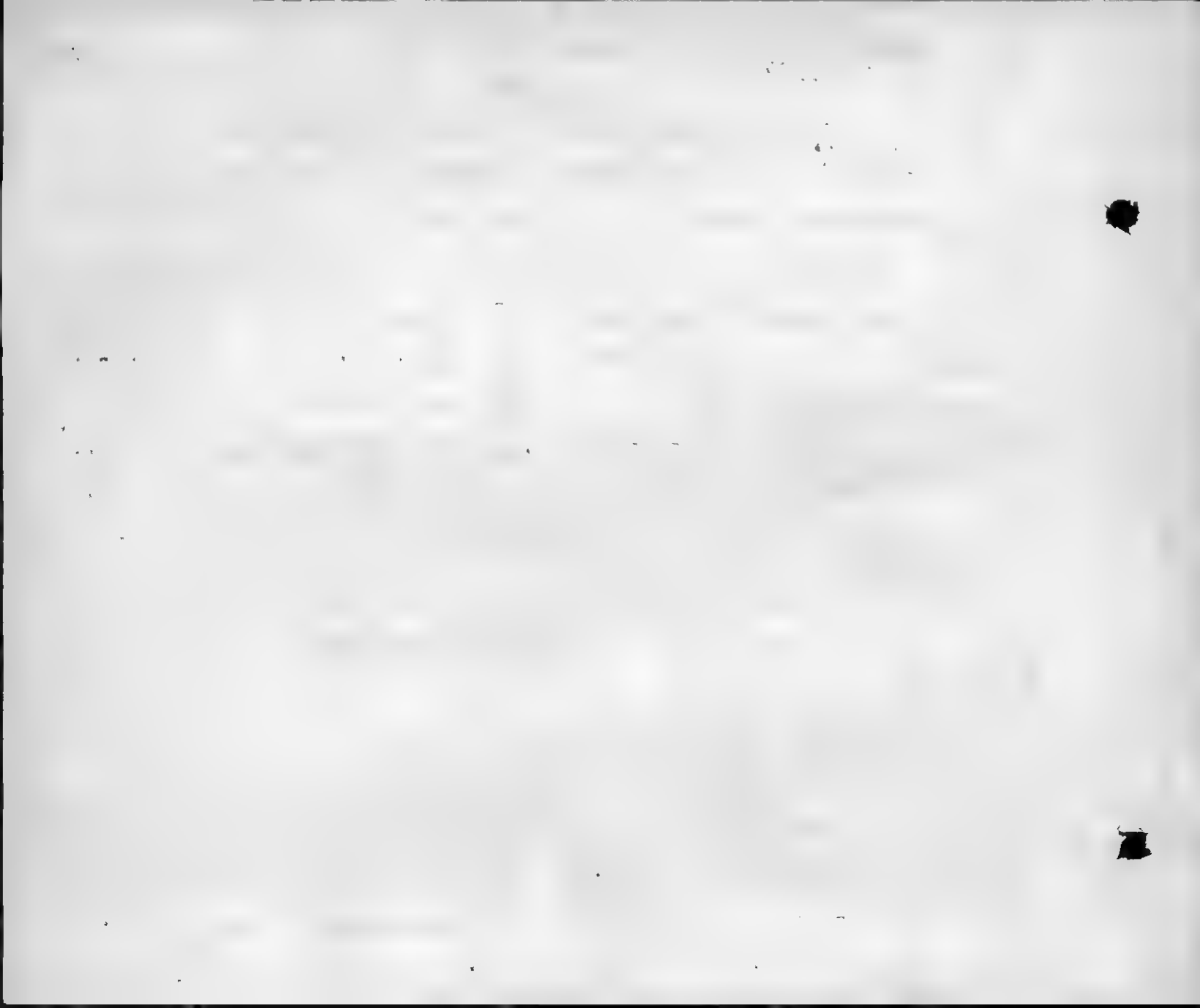
10921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10929**

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>12 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Retreat</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>WALKENSHAW</u> Last _____ 4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>19 60</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>4-4-1895</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (State or foreign country) <u>Midland, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Walkenshaw</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Barber</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>215-20-5635</u> 17. INFORMANT <u>Mrs. Andrew Taylor</u> Address <u>Cheverly, Md. 6214 Kilmer St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY THROMBOSIS, LEFT</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>OCTOBER 10, 1960</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10-13-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u> 22d. LOCATION (City, town, or county) <u>Eckhart</u> (State) <u>Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bela H. Hutter</u> ADDRESS <u>23 E. Main, Frostburg, Md.</u> 24a. REC'D BY REGISTRAR <u>OCT 14 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Colton S. Kraw</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-permission, or removal.



CERTIFICATE OF DEATH

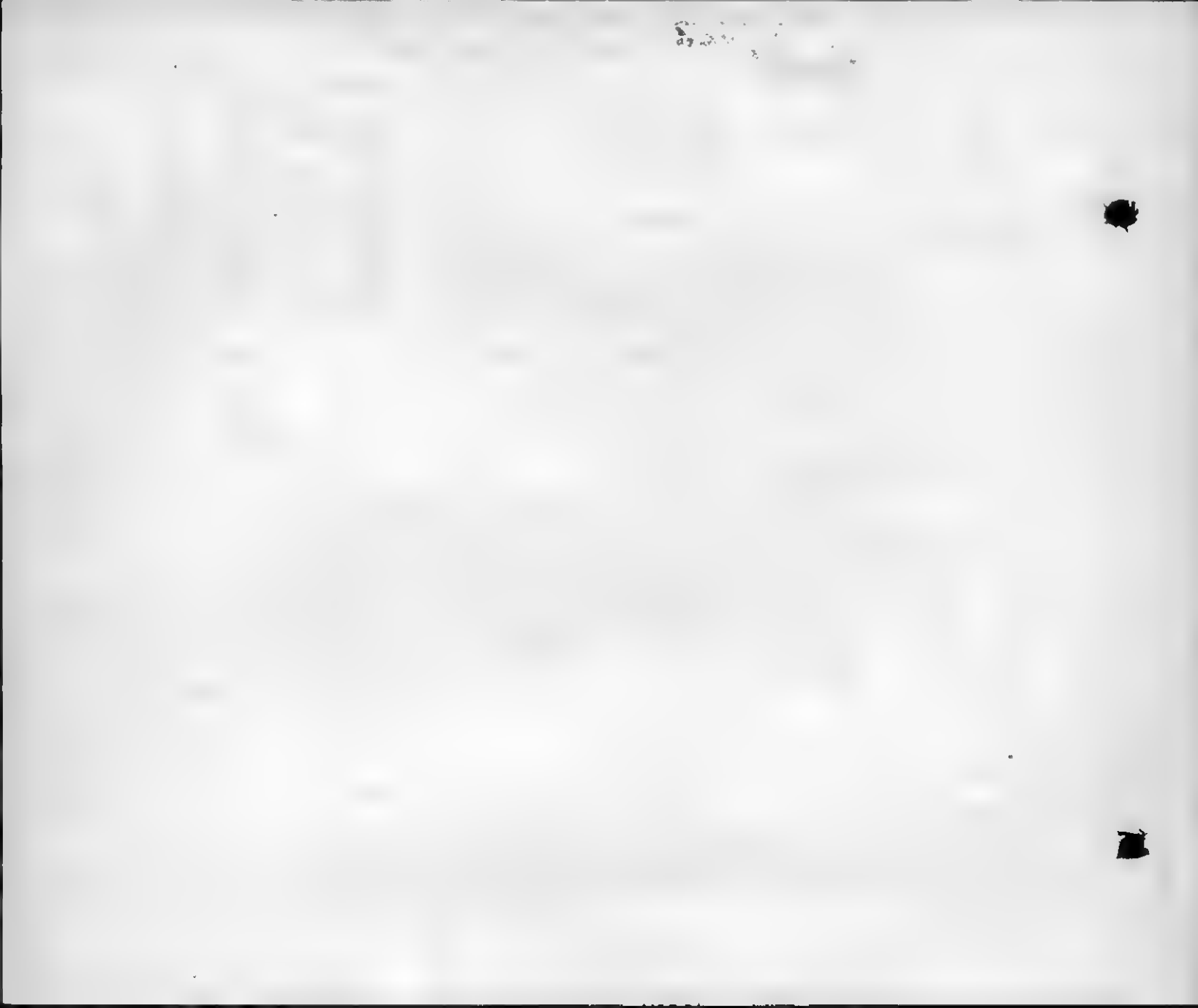
Reg. Dist. No. 10930

10922

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN IB 48yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION III6 Kentucky Ave		e. STREET ADDRESS III6 Kentucky Ave.	
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Weaver		4. DATE OF DEATH Month 10 Day 16 Year 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1881
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Pottstown, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry S. Weaver		14. MOTHER'S MAIDEN NAME Matilda Lachman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 705-07-7014	
17. INFORMANT Naomi E. Weaver		Address III6 Kentucky Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strain DUE TO Right Central Hemorrhage with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Left Hemiplegia (b) Left Hemiplegia (c) Left Hemiplegia			INTERVAL BETWEEN ONSET AND DEATH 2 day 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 16, 1958 to Oct 16, 1960 , that I last saw the deceased alive on Oct 16, 1960 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland Md 21716	
DATE SIGNED Oct 19 1960			
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland Maryland			
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 1018-60	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct 19 1960		24b. REGISTRAR'S SIGNATURE Clay E. Durrett	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

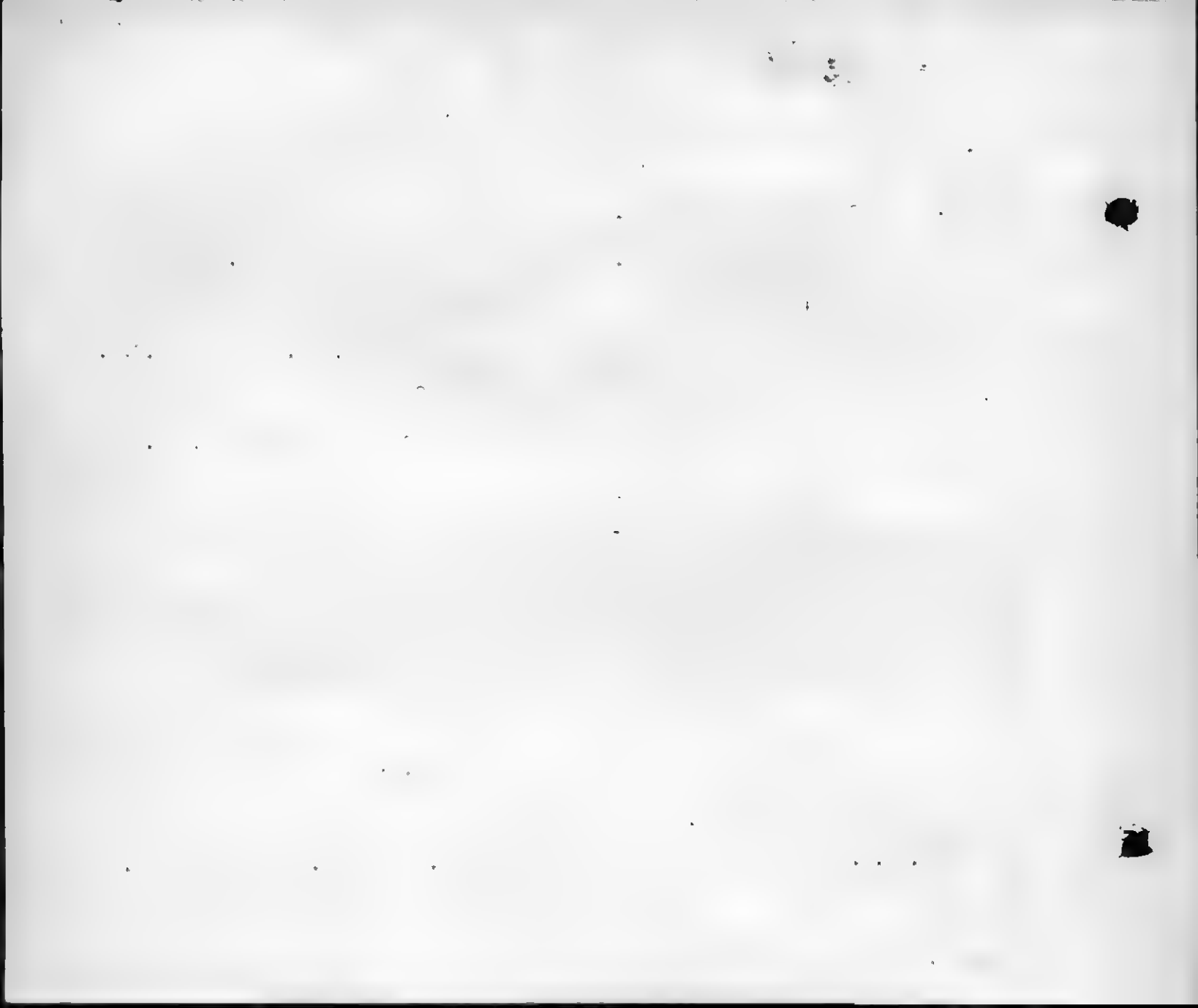
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10923

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10931

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EMORY J. WIGFIELD				4. DATE OF DEATH Month Day Year OCT. 16 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/76	
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant				10b. KIND OF BUSINESS OR INDUSTRY Own Business		11 BIRTHPLACE (State or foreign country) TOWN CREEK, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN WIGFIELD				14. MOTHER'S MAIDEN NAME DEBRA SHRYOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16 SOCIAL SECURITY NO. 232-54-3579		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Vasculat renal disease DUE TO (c) ?				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10.5. 19 60	
20f. (City or town) (County) (State) 10. 16 19 60							
21 I certify that (I) (the hospital) attended the deceased from 10.5. 19 60 to 10. 16 19 60 that (I) (we) last saw the deceased alive on 10. 16 19 60 and that death occurred at 1:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Dr. W.F. Williams				22b. DATE SIGNED 10. 21 60			
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/19/60		23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a RECEIVED BY REGISTRAR Oct 21 60			
				25b REGISTRAR'S SIGNATURE James S. Smith			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

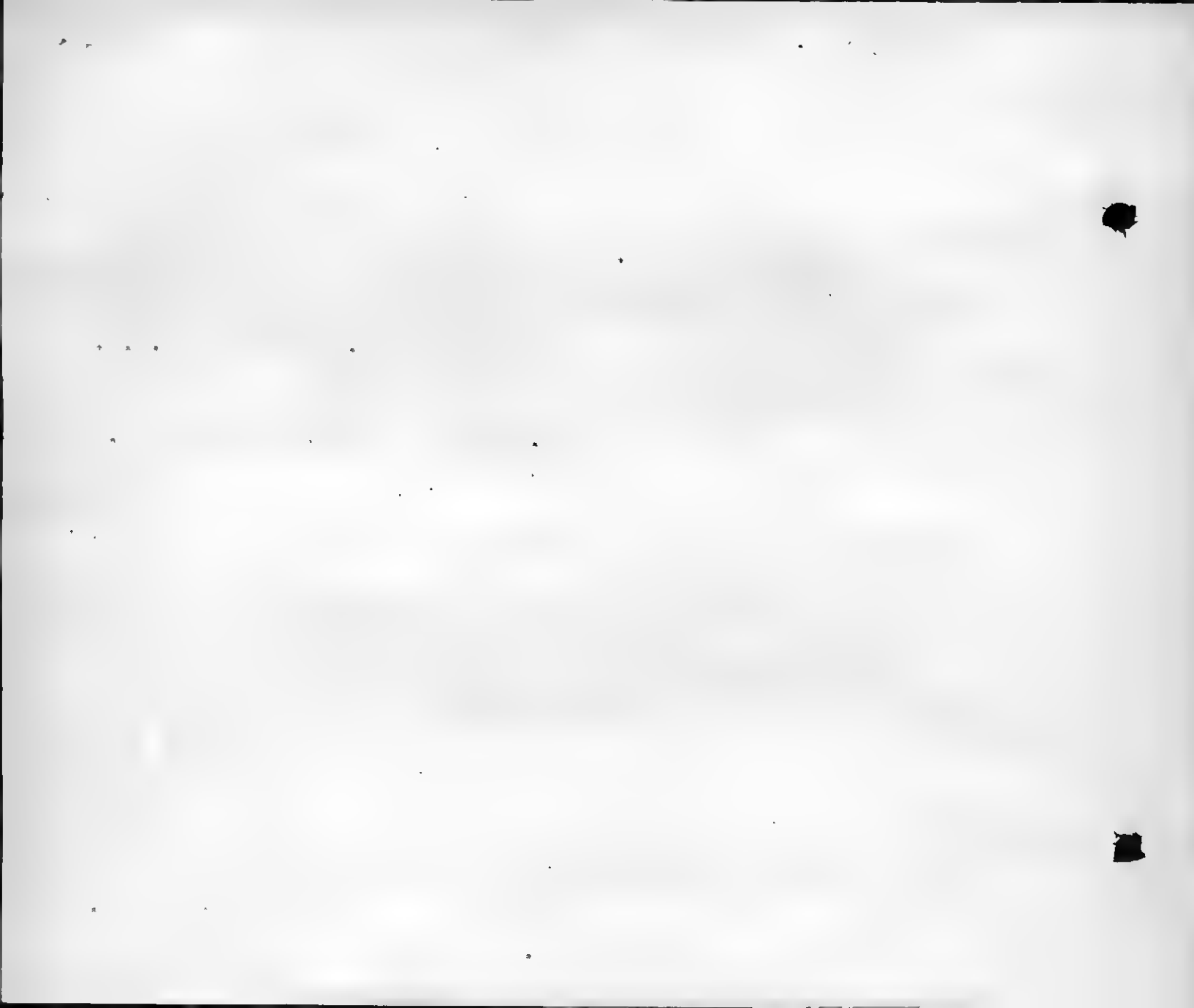
VR A15 (4)
15M 9/59

10951

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10932

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Railroad Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle E. Last WILSON		4. DATE OF DEATH Month 10/28/1960 Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1896
9. AGE (In years last birthday) 63 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Garrett CO. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Andrew Beeman		14. MOTHER'S MAIDEN NAME Dorothy Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Leonard Wilson, Midland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 Years 5 Years 5 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10 , 19 55 , to Oct 28 , 19 60 , that (I) (we) last saw the deceased alive on Oct 25 , 19 60 , and that death occurred at 1:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson M.D.		22b. DATE SIGNED Oct 28, 1960	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D.		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/1960	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONACONING, MD.	
25a. REC'D BY REGISTRAR DATE OCT 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

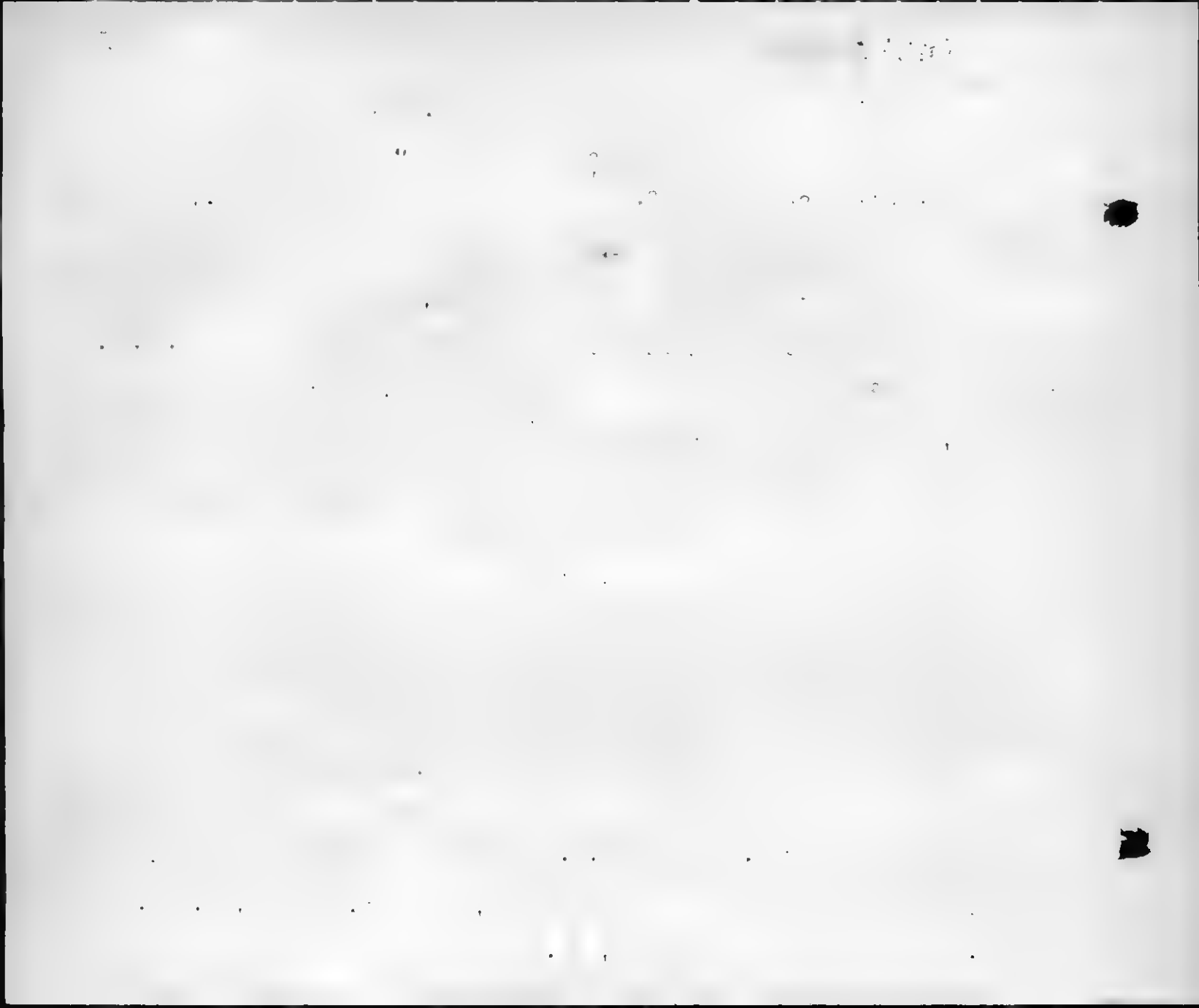


10924

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10933

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE		c. LENGTH OF STAY IN 1b 17 DAYS		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE			
d. NAME OF HOSPITAL (If not in hospital, write street address OR INSTITUTION) MEMORIAL HOSPITAL				f. STREET ADDRESS 26 NORTH WOODLAWN Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle Walter Last WIMER				4. DATE OF DEATH Month OCTOBER Day 26 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1878		9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ISAAC WIMER				14. MOTHER'S MAIDEN NAME MARY RAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO 232-07-2079		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Coronary Artery Disease + Occlusion							INTERVAL BETWEEN ONSET AND DEATH 30 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/9 19 60 to 10/26 19 60 , that (I) was last saw the deceased alive on Oct/26 19 60 , and that death occurred at 6:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Walter N. Himmler				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/27/60	
22c. PHYSICIAN'S NAME (Type) Walter N. Himmler M.D.				22d. ADDRESS 412 N. Mechanics St, Cumberland.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/60		23c. NAME OF CEMETERY OR CREMATORY Harper Cemetery,		23d. LOCATION (City, town, or county) (State) Nr. Harmon, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. House	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10934

10925		Item 9 Film 6273 10-27-60 et	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Bedford, PA. b. COUNTY Bedford, PA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bedford Rt. # 3 Box #218	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 75X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Lillie May Wolford		4. DATE OF DEATH Month Day Year October 20 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10 1873.
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Martin		14. MOTHER'S MAIDEN NAME Florence ? Grim	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. A. Robinette, Route 3, Bedford, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident DUE TO (c) Arteriosclerotic cardiac and cerebrovascular dis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis; old fractures of left arm and hip; osteoarthritis		INTERVAL BETWEEN ONSET AND DEATH 20 hours 2 1/2 months 6 + years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 5th, 1960, to October 20th, 1960, that (I) (we) last saw the deceased alive on October 20, 1960, and that death occurred at 7 PM, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10-21-60	
22c. PHYSICIAN'S NAME (Type) Dr. W. Doerner		22d. ADDRESS Algonquin Hotel, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 23, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) Augusta, W. Va. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs		25a. REC'D BY REGISTRAR ADDRESS Romney, W. Va. DATE OCT 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

10001

STATE OF NEW YORK

10001

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10926

CERTIFICATE OF DEATH

Reg. Dist. No. 10935

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d. STREET ADDRESS Jane Frazier Village	
3. NAME OF DECEASED (Type or print) First Stella Middle Rosettia Last Yankee		4. DATE OF DEATH Month Oct. Day 2 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia, Thomas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eliza Nazelrod		14. MOTHER'S MAIDEN NAME Elizabeth Hearst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT James E. Leary, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Chronic Myocarditis DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 450 General arteriosclerosis DUE TO 593 Chronic hepatitis (c) 304 Senile psychosis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19th, 1960 , to Oct. 2nd, 1960 , that I last saw the deceased alive on Oct. 1st, 1960 , and that death occurred at 4:50 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md.	
PHYSICIAN'S NAME (Type) James E. McLean, MD.		DATE SIGNED 10/3/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/60	22c. NAME OF CEMETERY OR CREMATORY Allegany County Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR OCT 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10528

11103

<p>1. Name of deceased</p>	
<p>2. Sex</p>	
<p>3. Age</p>	
<p>4. Date of death</p>	
<p>5. Place of death</p>	
<p>6. Cause of death</p>	
<p>7. Signature of physician</p>	
<p>8. Signature of registrar</p>	
<p>9. Date of registration</p>	
<p>10. Remarks</p>	